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Supreme Court, U.S.
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No.

IN THE SUPREME COURT OF THE
UNITED STATES

October Term, 1991

ROBERT P. CASEY, et al.,
Petitioners

v.

PLANNED PARENTHOOD OF
SOUTHEASTERN PENNSYLVANIA, et al.,
Respondents

Petition for Certiorari to the United States Court of Appeals for the Third Circuit

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APPENDIX TO PETITION FOR CERTIORARI

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Filed October 21, 1991

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 90-1662

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA
REPRODUCTIVE HEALTH AND COUNSELING CENTER WOMEN'S HEALTH SERVICES, INC.
WOMEN'S SUBURBAN CLINIC
ALLENTOWN WOMEN'S CENTER
NORTHEAST WOMEN'S CENTER
ALLEN, THOMAS, M.D., on behalf of himself and all others similarly situated

v.

CASEY, ROBERT P.
RICHARDS, N. MARK
PREATE, ERNEST, personally and in their official capacities, and
MARINO, MICHAEL D., personally and in his official capacity, together with all others similarly situated

Robert P. Casey,
N. Mark Richards and
Ernest D. Preate, Jr.,

Appellants

On Appeal From the United States District Court
For the Eastern District of Pennsylvania
(D.C. Civil Action No. 88-3228)

Argued February 25, 1991

BEFORE: STAPLETON, ALITO, and SEITZ,
Circuit Judges

(Opinion Filed October 21, 1991)

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OPINION OF THE COURT

STAPLETON, *Circuit Judge*:

Five abortion clinics and one physician (the "clinics") raise a facial constitutional challenge to certain 1988 and 1989 amendments to the Pennsylvania Abortion Control Act of 1982 (the

"Act"). *See* 18 Pa. Cons. Stat. Ann. §§ 3201-3220 (1983 & Supp. 1991). The United States District Court for the Eastern District of Pennsylvania held that §§ 3205 (informed consent), 3206 (parental consent), 3209 (spousal notice), 3214(a) (reporting requirements), and 3207(b) and 3214(f) (public disclosure of clinics' reports) violate the Due Process Clause of the Fourteenth Amendment to the United States Constitution. The Commonwealth defendants (the "Commonwealth") appeal. Because we find unconstitutional only § 3209, which requires notice to a spouse of a planned abortion, we will affirm in part and reverse in part.

I.

The clinics filed a complaint alleging that certain 1988 amendments to the Pennsylvania Abortion Control Act of 1982 were facially unconstitutional. The district court issued a preliminary injunction. Thereafter, the court stayed all proceedings pending the Supreme Court's decision in *Webster v. Reproductive Health Services* in the summer of 1989. After the *Webster* decision, the Pennsylvania legislature passed further amendments to the Act. The clinics filed an amended complaint to include the 1989 amendments within the scope of their challenge, and the district court extended the preliminary injunction to include the 1989 amendments. The district court then conducted a three-day trial and issued an opinion holding several sections of the Act unconstitutional. The Commonwealth filed this timely appeal. The clinics have not cross-appealed on the provisions upheld by the district court. The district court had subject matter jurisdiction pursuant to 28 U.S.C. §§ 1331,

1343. We have appellate jurisdiction pursuant to 28 U.S.C. § 1291.

II.

In *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), the Supreme Court declined to reconsider *Roe v. Wade*, 410 U.S. 113 (1973), because the Missouri abortion regulations at issue in *Webster* did not conflict with *Roe*, which held that a statute which "criminalized the performance of *all* abortions, except when the mother's life was at stake . . . unconstitutionally infringed the right to an abortion." *Webster*, 492 U.S. at 521 (opinion of Rehnquist, C.J.). Like *Webster*, this appeal does not directly implicate *Roe*; this case involves the regulation of abortions rather than their outright prohibition. The threshold question is whether the standard of review of abortion regulations promulgated by the Court in *Roe* and in later cases such as *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983), and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), has survived *Webster* and the Court's subsequent decision in *Hodgson v. Minnesota*, 110 S. Ct. 2926 (1990).

As Justice O'Connor cogently observed in an equal protection case alleging racial discrimination, a "dispute regarding the appropriate standard of review may strike some as a lawyers' quibble over words, but it is not. The standard of review establishes when the Court and Constitution allow the Government to employ racial classifications. A lower standard signals that the Government may resort to racial distinctions more readily." *Metro Broadcasting, Inc. v. FCC*, 110 S. Ct. 2997, 3033 (1990) (O'Connor, J.,

dissenting). Similarly, the standard of review used for abortion legislation establishes the degree to which the government may regulate abortion. Because of its importance to the resolution of the issues before us, we discuss at some length our reasons for selecting the standard we will subsequently use in analyzing the challenged provisions of the Pennsylvania Act. We will first examine the different standards of review that have been suggested by various Justices as appropriate for reviewing abortion regulations. Then we will consider the rules of *stare decisis* that must be employed in determining which of these standards we must apply in this case.

A.

The choice of a standard of review in a substantive due process case turns on whether a "fundamental right" is implicated. The Justices of the Supreme Court were divided in *Roe v. Wade* and have continued to be divided over whether the right to an abortion is a fundamental right under the Due Process Clause.[1] Accordingly, they have

1. The Due Process Clause of the Fourteenth Amendment states: "nor shall any State deprive any person of life, liberty, or property, without due process of law." U.S. Const. amend. xiv. Though the Due Process Clause, read literally, is a guarantee only of fair procedures when the government deprives a person of life, liberty, or property, the Supreme Court has held under the "substantive due process" doctrine that there is more to the Due Process Clause than this guarantee of procedural fairness. Government interference with personal rights within the scope of the life, liberty, or property umbrella of the Due Process Clauses must be justified by a legitimate state interest; government interference with a "fundamental right" may be justified only by the most important of state interests.

disagreed over the proper standard to apply in reviewing abortion regulations. The majority in *Roe* concluded that abortion was a fundamental right and, therefore, applied strict scrutiny review, the standard of review generally applied in fundamental rights cases. *See Roe*, 410 U.S. at 155. The dissenters in *Roe* contended that abortion was not a fundamental right and thus judicial review of abortion regulations under the Due Process Clause should be no different from review of any social or economic legislation implicating a liberty interest. Therefore, they urged that the Court apply the deferential rational basis test traditionally used to review social and economic legislation. *See id.* at 173 (Rehnquist, J., dissenting).[2] Justice O'Connor has referred to the right to abortion as a "limited" fundamental right and adopted a middle ground between these two positions. She uses the strict scrutiny standard if the regulation at issue causes an "undue burden" on a woman's abortion decision and the rational basis standard if it does not. *See Akron*, 462 U.S. at 453, 465 n. 10 (O'Connor, J., dissenting).

2. The *Roe* dissenters argued that only those rights "implicit in the concept of ordered liberty" or "deeply rooted in this Nation's history and tradition" are fundamental rights and that the right to an abortion does not meet that standard. *See Roe*, 410 U.S. at 174 (Rehnquist, J., dissenting); *Thornburgh*, 476 U.S. at 793 (White, J., dissenting). The *Roe* majority stated that there is a fundamental right to privacy. This right includes "the right of the *individual*, married or single, to be free from unwarranted government intrusions into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

1.

In *Roe*, the Court held that the fundamental right of privacy protected by the Due Process Clause of the Fourteenth Amendment was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." *Roe*, 410 U.S. at 153. Thus, the Court stated that a regulation limiting that fundamental right must meet the strict scrutiny test; it must be justified by a "compelling state interest" and "must be narrowly drawn" to serve that interest. *Id.* at 155. The Court held that the state's interests in maternal health and in the potential life of the fetus become compelling at different points in a woman's pregnancy. The state's interest in maternal health is compelling during the second and third trimesters; the state's interest in potential life is compelling when the fetus is viable, that is, during the third trimester. *Id.* at 162-64.

In dissent in *Hodgson*, the most recent abortion case, Justice Marshall, joined by Justices Brennan and Blackmun, summarized the approach of cases such as *Roe*, *Doe v. Bolton*, 410 U.S. 179 (1973), *Akron*, and *Thornburgh*: "we have subjected state laws limiting [the abortion] right to the most exacting scrutiny, requiring a State to show that such a law is narrowly drawn to serve a compelling interest. Only such strict judicial scrutiny is sufficiently protective of a woman's right to make the intensely personal decision whether to terminate her pregnancy." *Hodgson*, 110 S. Ct. at 2952 (Marshall, J., dissenting) (citations omitted).

2.

A statute is struck down under rational basis review only if it is not rationally related to a legitimate state interest. The test is a deferential one, and state legislation is rarely invalidated as not rationally related to a legitimate state interest. *See Williamson v. Lee Optical*, 348 U.S. 483, 487 (1955); *Ferguson v. Skrupa*, 372 U.S. 726, 730 (1963).

In *Roe*, Justice White and then-Justice Rehnquist dissented and, applying rational basis review, would have upheld Texas' criminal prohibition of abortion. In dissent in *Thornburgh*, Justice White, joined by Justice Rehnquist, stated his reasoning:

> State action impinging on individual interests need only be rational to survive scrutiny under the Due Process Clause, and the determination of rationality is to be made with a heavy dose of deference to the policy choices of the legislature. Only "fundamental" rights are entitled to the added protection provided by strict judicial scrutiny of legislation that impinges upon them. I can certainly agree with the proposition—which I deem indisputable—that a woman's ability to choose an abortion is a species of "liberty" that is subject to the general protections of the Due Process Clause. I cannot agree, however, that this liberty is so "fundamental" that restrictions upon it call into play anything more than the most minimal judicial scrutiny.

Thornburgh, 476 U.S. at 789-90 (White, J., dissenting) (citations omitted). In *Webster*, the plurality of Chief Justice Rehnquist, Justice White,

and Justice Kennedy asked whether the challenged regulation "permissibly furthers the State's interest in protecting potential human life," *Webster*, 492 U.S. at 519-20, a standard that, at least for present purposes, we equate with rational basis review. *See also Hodgson*, 110 S. Ct. at 2969 (Kennedy, J., concurring and dissenting) (two-parent notification requirement represents "permissible, reasoned" attempt to further parents' rights).

3.

Justice O'Connor has taken middle ground between these two positions. She has consistently stated that she would subject an abortion regulation to strict scrutiny review *only if* the regulation "unduly burdens" a woman's freedom to decide whether to terminate her pregnancy; otherwise, she would employ rational basis review. *See Akron*, 462 U.S. at 453 (O'Connor, J., dissenting) (citation omitted) ("If the particular regulation does not 'unduly burden' the fundamental right, then our evaluation of that regulation is limited to our determination that the regulation rationally relates to a legitimate state purpose."); *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting) (repeating undue burden standard and citing dissent from *Akron*); *Webster*, 492 U.S. at 530 (O'Connor, J., concurring) (same); *Hodgson*, 110 S. Ct. at 2949-50 (O'Connor, J., concurring) (same).

Justice O'Connor has adopted the undue burden standard because of the "limited nature of the fundamental right that has been recognized in the abortion cases." *Akron*, 462 U.S. at 465 n.10 (O'Connor, J., dissenting). In support of her

position, she has referenced both previous abortion cases and other fundamental rights cases.[3]

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3. In the abortion context, the pedigree of the undue burden standard can be traced to Justice Powell's opinion for the majority in *Maher v. Roe*, a government funding case:

> *Roe* did not declare an unqualified "constitutional right to an abortion," as the District Court seemed to think. Rather, the right protects the woman from *unduly burdensome* interference with her freedom to decide whether to terminate her pregnancy. It implies no limitation on the authority of a State to make a value judgment favoring childbirth over abortion.

Maher v. Roe, 432 U.S. 464, 473-74 (1977) (emphasis added). Chief Justice Burger added, "The Court's holdings in [*Roe* and *Doe v. Bolton*] simply require that a State not create an *absolute barrier* to a woman's decision to have an abortion." *Id.* at 481 (Burger, C.J., concurring) (emphasis added). In a later funding case, Justice Stewart stated for the Court that *Roe* protects the woman from "unduly burdensome interference," such as the "severe criminal sanctions" in *Roe* or the "absolute requirement of spousal consent" in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976). *Harris v. McRae*, 448 U.S. 297, 314 (1980). Though *Maher* and *Harris* involved funding and thus presented a somewhat different analytical problem than general regulation of abortion, Justice O'Connor has interpreted those cases as providing the correct standard of review for all abortion regulations. *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting) ("These principles for evaluating state regulation of abortion were not newly minted in my dissenting opinion in *Akron*."). Justice O'Connor has also pointed out that the results reached in *Danforth* and *Bellotti v. Baird*, 443 U.S. 622 (1979) ("*Bellotti II*"), the most important non-funding cases between *Roe* and *Akron*, are consistent with the undue burden approach. *See Akron*, 462 U.S. at 461-62 n.8, 464 (O'Connor, J., dissenting). Beyond the abortion context, Justice O'Gonnor has pointed to other fundamental rights cases where the Court has required a significant or substantial infringement on the fundamental right in order to trigger strict scrutiny. *See, e.g., Carey v. Population Services International*, 431 U.S. 678, 689 (1977) (addressing state ban on nonmedical contraceptives, Court stated that strict scrutiny

With respect to the concept of "undue burden," Justice O'Connor explained in *Akron* that an undue burden occurs when a regulation imposes an "absolute obstacle[] or severe limitation[] on the abortion decision," not merely when a regulation "may 'inhibit' abortions to some degree." *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting). She repeated this definition in other cases. In *Thornburgh*, she stated that "an undue burden will generally be found in situations involving absolute obstacles or severe limitations on the abortion decision." *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting). And in *Hodgson*, she observed that "the 'primary constitutional deficiency lies in [the notification statute's] imposition of an *absolute limitation* on the minor's right to obtain an abortion.'" *Hodgson*, 110 S. Ct. at 2950-51 (O'Connor, J., concurring) (emphasis added) (quoting *Planned Parenthood v. Danforth*, 428 U.S. 52, 90 (1976)). Also in *Hodgson*, Justice O'Connor approved the judicial bypass procedure for the two-parent notification requirement on the grounds that it "would not impose parental approval as an *absolute condition* upon the minor's right." *Id.* at 2951 (quoting *Danforth*, 428 U.S. at 91) (emphasis added).[4]

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is appropriate only when law imposes "significant burden" on protected right); *Zablocki v. Redhail*, 434 U.S. 374, 387 (1978) (heightened scrutiny is appropriate when law interferes "directly and substantially with the right to marry" and "citizens suffer a serious intrusion into their freedom of choice in an area in which we have held such freedom to be fundamental.").

4. As we read Justice O'Connor's explications of the concept of "undue burden," they are all consistent with the view that

B.

Having identified the three approaches that the Justices have suggested for reviewing abortion regulations, we must now decide which standard is presently the law of the land. As we have noted, the Court applied strict scrutiny review in *Roe*, *Doe*, *Akron* and *Thornburgh*. We thus must review *Webster* and *Hodgson* to determine if the standard of review used in those cases displaced strict scrutiny as the standard binding on lower courts. In making that determination, we will apply several principles of law that constrain lower courts in their decisionmaking.

1.

Decisions of the Supreme Court regarding federal law and the Constitution are binding on the lower courts. There is no room in our system for departure from this principle, for if it were otherwise, the law of the land would quickly lose its coherence. *See Hutto v. Davis*, 454 U.S. 370, 375 (1982). The Supreme Court with its limited docket would become irrelevant in all but the handful of cases that reached it.

To say that such decisions are binding, however, does not suffice in the current context. We must determine what components of a Supreme Court

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the right to elect not to carry to term is a constitutional right of each individual woman. Where it is clear that a governmental regulation will restrict the ability of *some* women to choose an abortion, we believe the issue of whether there is an undue burden turns on the degree of restriction that the affected women will experience. Accordingly, whether the adversely affected group is but a small fraction of the universe of pregnant women desiring an abortion seems to us irrelevant to that issue.

decision constitute precedent binding on lower courts. In constitutional cases, the Court's opinions usually include two major aspects. First, the Court provides the legal standard or test that is applicable to laws implicating a particular constitutional provision. This is part of the reasoning of the decision, the *ratio decidendi*.[5] Second, the Court applies that standard or test to the particular facts of the case that the Court is confronting—in other words, it reaches a specific result using the standard or test. *See, e.g., Barnes v. Glen Theatre, Inc.*, 111 S. Ct. 2456 (1991) (applying four-part *O'Brien* test and holding ban on nude dancing constitutional); *Employment Division, Dept. of Human Resources v. Smith*, 110 S. Ct. 1595 (1990) (applying new Free Exercise Clause standard to uphold state ban on peyote use).

5. For almost every constitutional provision in the Bill of Rights and the Fourteenth Amendment, the Supreme Court has adopted a standard or test, usually known afterwards by the name of the case adopting it, to flesh out the constitutional language and guide future resolution of cases that arise under those provisions. A brief and inexhaustive list includes: *Lemon v. Kurtzman*, 403 U.S. 602 (1971), for the Establishment Clause; *New York Times Co. v. Sullivan*, 376 U.S. 254 (1964), for libel; *Employment Division, Dept. of Human Resources v. Smith*, 110 S. Ct. 1595 (1990), for Free Exercise claims; *Brandenburg v. Ohio*, 395 U.S. 444 (1969), for threatening speech; *United States v. O'Brien*, 391 U.S. 367 (1968), for First Amendment expressive conduct; *National Treasury Employees Union v. Von Raab*, 489 U.S. 656 (1989), for drug testing; *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469 (1989), for state affirmative action; *Metro Broadcasting, Inc. v. FCC*, 110 S. Ct. 2997 (1990) for federal affirmative action; *Mathews v. Eldridge*, 424 U.S. 319 (1976), for procedural due process; *Blockburger v. United States*, 284 U.S. 299 (1932), and now *Grady v. Corbin*, 110 S. Ct. 2084 (1990), for double jeopardy.

As a lower court, we are bound by both the Supreme Court's choice of legal standard or test and by the result it reaches under that standard or test. As Justice Kennedy has stated, courts are bound to adhere not only to results of cases, but also "to their explications of the governing rules of law." *County of Allegheny v. ACLU, Greater Pittsburgh Chapter*, 492 U.S. 573, 668 (1989) (Kennedy, J., dissenting); *see also Marks v. United States*, 430 U.S. 188, 194 (1977) (previous case provided "governing standards"). Our system of precedent or *stare decisis* is thus based on adherence to both the reasoning and result of a case, and not simply to the result alone. This distinguishes the American system of precedent, sometimes called "rule stare decisis," from the English system, which historically has been limited to following the results or disposition based on the facts of a case and thus referred to as "result stare decisis." *See* Note, *The Precedential Value of Supreme Court Plurality Decisions*, 80 Colum. L. Rev. 756, 757 n.7 (1980) ("The American system of precedent places substantially greater reliance on the reasoning component of judicial decisions than, for example, the British system, where the House of Lords issues individual opinions with the understanding that only the specific result will have precedential force."); *see generally* R. Aldisert, *The Judicial Process* 618-35, 777-801 (1976).[6]

6. The lower courts in constitutional matters universally follow both the Supreme Court's choice of legal standard and the specific results the Court has reached by applying that legal standard. *See, e.g., Reuber v. Food Chemical News, Inc.*, 925 F.2d 703, 714-18 (4th Cir. 1991) (applying *New York Times* actual malice standard in defamation case); *Vandiver v. Hardin County Board of Education*, 925 F.2d 927, 931-34 (6th

2.

Like lower courts, the Supreme Court applies principles of *stare decisis* and recognizes an obligation to respect both the standard announced and the result reached in its prior cases. Unlike lower courts, the Supreme Court is free to change the standard or result from one of its earlier cases when it finds it to be "unsound in principle [or] unworkable in practice." *Garcia v. San Antonio Metropolitan Transit Authority*, 469 U.S. 528, 546 (1985). Accordingly, when a majority of the Justices announce in the course of deciding a case that they are substituting a new standard or result for that used in a prior case, the substitution is effected, and the lower courts are thereafter bound to follow the new standard or result. *See, e.g., Employment Division, Dept. of Human Resources v. Smith*, 110 S. Ct. 1595 (1990); *Vandiver v. Hardin County Board of Education*, 925 F.2d 927 (6th Cir. 1991) (applying new *Smith* test).

Occasionally, the Supreme Court's decision in a case reveals that a standard established in an earlier case no longer commands the allegiance of a majority of the Justices, but also reveals that no single substitute is endorsed by that majority of the Justices. Thereafter, the lower courts must determine whether to apply the old standard or, if

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Cir. 1991) (applying *Smith* Free Exercise Clause standard); *United States v. Pungitore*, 910 F.2d 1084, 1109-1112 (3d Cir. 1990) (applying *Grady v. Corbin* double jeopardy test); *United States v. Cruz*, 910 F.2d 1072, 1078-79 (3d Cir. 1990) (applying *Duckworth* test for adequacy of *Miranda* warnings); *United States v. American Investors of Pittsburgh, Inc.*, 879 F.2d 1087, 1106-07 (3d Cir. 1989) (applying *Leon* standard for defective search warrants).

not, what standard to apply. Fortunately, the Supreme Court has instructed the lower courts on how to resolve these issues.

Marks v. United States, 430 U.S. 188 (1977), was a criminal prosecution under a statute barring the interstate transportation of obscene materials. The Court had previously established that the statute was to be interpreted in accordance with the definition of obscenity fashioned by the Supreme Court under the Free Speech Clause of the First Amendment. In response to a contention based on the Ex Post Facto Clause, the Supreme Court in *Marks* had to determine what the law of the land regarding obscenity had been at the time of the defendant's alleged offense. It therefore reviewed its more recent obscenity jurisprudence. In *Roth v. United States*, 354 U.S. 476, 489 (1957), the Court had declared the test to be "whether to the average person, applying contemporary community standards, the dominant theme of the material taken as a whole appeals to the prurient interest." Some years later in *Memoirs v. Massachusetts*, 383 U.S. 413 (1966), a plurality opinion joined only by three Justices announced that a work is not obscene unless "three elements . . . coalesce:"

> [I]t must be established that (a) the dominant theme of the material taken as a whole appears to a prurient interest in sex; (b) the material is patently offensive because it affronts contemporary community standards relating to the description or representation of sexual matters; and (c) the material is utterly without redeeming social value.

383 U.S. at 418. The plurality opinion in *Memoirs* decided that *Fanny Hill* was not obscene when

judged by this standard and, accordingly, that the defendants' conviction had to be overturned. Three additional Justices concurred in this result but did so utilizing different rules of law: two stated that the First Amendment shields all speech including obscenity; one stated that the First Amendment protects all but "hard core pornography." Three Justices dissented.

The *Marks* Court was required to determine whether the legal standard announced in *Roth* had remained the law of the land after *Memoirs* or whether it had been superseded by a new standard in *Memoirs*. Despite the fact that no new legal standard had commanded the allegiance of a majority of the Justices in *Memoirs*, the *Marks* Court held that *Roth*'s standard did not survive *Memoirs* because a majority of Justices in *Memoirs* rejected the *Roth* standard. *Marks* thus stands for a very important proposition: a legal standard endorsed by the Court ceases to be the law of the land when a majority of the Court in a subsequent case declines to apply it, even if that majority is composed of Justices who disagree on what the proper standard should be.

Having decided that the *Roth* standard had ceased to control, the *Marks* Court also determined what standard had taken its place. The Court concluded that the *Memoirs* plurality opinion had become the law of the land. The court explained that "[w]hen a fragmented court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds.'" *Marks*, 430 U.S. at 193

(quoting *Gregg v. Georgia*, 428 U.S. 153, 169 n.15 (1976) (opinion of Stewart, Powell, and Stevens, JJ.)). The Justices in the plurality in *Memoirs* were those who concurred on the narrowest grounds.

Thus, *Marks* stands for a second important proposition: the controlling opinion in a splintered decision is that of the Justice or Justices who concur on the "narrowest grounds." The principal objective of this *Marks* rule is to promote predictability in the law by ensuring lower court adherence to Supreme Court precedent. This objective requires that, whenever possible, there be a single legal standard for the lower courts to apply in similar cases and that this standard, when properly applied, produce results with which a majority of the Justices in the case articulating the standard would agree. In a run-of-the-mill case where a majority of the Justices endorse a single legal standard, *see, e.g., Lemon v. Kurtzman*, 403 U.S. 602 (1971), lower courts simply follow that standard. In splintered decisions such as *Memoirs* where no single rationale "enjoys the assent of five Justices," the situation becomes more complex, but the controlling principle is the same. Where a Justice or Justices concurring in the judgment in such a case articulates a legal standard which, when applied, will necessarily produce results with which a majority of the Court from that case would agree, that standard is the law of the land. In a constitutional case where (1) there is a 5-4 decision or where there are only two opinions in the majority and (2) the majority votes to uphold a law as constitutional, the "narrowest grounds" principle will identify as authoritative the standard articulated by a Justice or Justices that would uphold the fewest laws as constitutional.

Conversely, in a constitutional case where (1) there is a 5-4 split or there are only two opinions in the majority and (2) the majority strikes down a law as unconstitutional, the authoritative standard will be that which would invalidate the fewest laws as unconstitutional.[7]

In splintered Supreme Court decisions where there has been a common denominator standard that would necessarily produce results with which a majority of the Justices from the controlling case would agree, the Supreme Court and the lower courts have consistently identified as binding precedent the opinion setting forth that standard. *See Gregg v. Georgia*, 428 U.S. 153, 169 n.15 (1976) (identifying three-Justice plurality opinion from *Furman v. Georgia*, 428 U.S. 238 (1972), as binding); *S.J. Groves & Sons Co. v. Fulton County*, 920 F.2d 752 (11th Cir. 1991) (following Chief Justice Burger's opinion from *Fullilove v. Klutznick*, 448 U.S. 448 (1980)); *Lundblad v. Celeste*, 874 F.2d 1097 (6th Cir. 1989) (following Justice Stewart's opinion in *Elrod v. Burns*, 427 U.S. 347 (1976)); *Stegmaier v. Trammell*, 597 F.2d 1027 (5th Cir. 1979) (same); *Islamic Center of Mississippi,*

7. When six or more Justices join in the judgment and they issue three or more opinions, the situation is slightly more complex. In those cases, the idea is to locate the opinion of the Justice or Justices who concurred on the narrowest grounds *necessary to secure a majority*. In other words, a lower court should not follow an opinion that, though part of the majority in that case, was unnecessary to secure a five-Justice majority. Thus, if three Justices issue the broadest opinion, two Justices concur on narrower grounds, and one Justice concurs on still-narrower grounds, the two-Justice opinion is binding because that was the narrowest of the opinions necessary to secure a majority.

Inc. v. City of Starksville, 876 F.2d 465 (5th Cir. 1989) (following Justice O'Connor's opinion in *Pennsylvania v. Delaware Valley Citizens Council for Clean Air*, 483 U.S. 711 (1987) ("*Delaware Valley II*"); *Student Public Interest Research Group of New Jersey, Inc. v. AT&T Bell Laboratories*, 842 F.2d 1436 (3d Cir. 1988) (same).[8]

The binding opinion from a splintered decision is as authoritative for lower courts as a nine-Justice opinion. While the opinion's symbolic and perceived authority, as well as its duration, may be less, that makes no difference for a lower court. This is true even if only one Justice issues the binding opinion. In *Blum v. Witco Chemical Corp.*, 888 F.2d 975, 981 (3d Cir. 1989), for example, we concluded, as has every other court of appeals to address the issue, that Justice O'Connor's concurring opinion in *Delaware Valley II* governed subsequent counsel fee cases even though no other Justice joined that opinion. We acknowledged that, "[a]lthough there is some awkwardness in attributing precedential value to an opinion of one Supreme Court justice to which no other justice adhered, it is the usual practice when that is the determinative opinion." *Blum*, 888 F.2d at 981.

In sum, the effect of following the wrong opinion from a splintered decision is the same as affirmatively declaring that a Supreme Court majority opinion is not binding. By following the

8. In rare cases, no common denominator exists beyond agreement on the result in that particular case. *See United States v. Eckford*, 910 F.2d 216 (5th Cir. 1990) (finding no common denominator and thus no binding opinion in *Baldasar v. United States*, 446 U.S. 222 (1980)); *Schindler v. Clerk of Circuit Court*, 715 F.2d 341 (7th Cir. 1983) (same).

opinion that comports with the *Marks* principle, we respect the decision of a majority of the Court and thus fulfill our obligation to comply with decisions of the Supreme Court.

3.

With this background, we turn to the Supreme Court's abortion jurisprudence to determine whether the strict scrutiny legal standard endorsed by the Court in *Roe*, *Akron*, and *Thornburgh* remains the applicable standard after *Webster* and *Hodgson*. The primary issue in *Webster* was the constitutionality of Missouri's viability testing provision. The five Justices in the majority issued three opinions in upholding that viability testing provision. Chief Justice Rehnquist's opinion, joined by Justices White and Kennedy, upheld the provision under the "permissibly furthers" standard, the equivalent of rational basis review. Justice Scalia concurred, similarly rejecting strict scrutiny review of abortion regulations and arguing that *Roe* should be explicitly overruled. The four Justices in dissent would have applied the traditional strict scrutiny test.[9]

In her concurring opinion, Justice O'Connor used the undue burden standard that she had articulated in past dissents. She concluded that Missouri's viability testing requirement was

9. Four Justices dissented over the interpretation of the Missouri statute. The dissenters agreed, however, that the statute as interpreted by the majority survived strict scrutiny review. Thus, all nine members of the Court concluded that the statute as interpreted by the majority was constitutional, but for four different reasons. In any event, five Justices rejected strict scrutiny, and the narrowest opinion of those five Justices was that of Justice O'Connor.

constitutional because it did not impose an undue burden on a woman's abortion decision and was rationally related to a legitimate state interest. She stated:

> It is clear to me that requiring the performance of examinations and tests useful to determining whether a fetus is viable, when viability is possible, and when it would not be medically imprudent to do so, does not impose an undue burden on a woman's abortion decision. *On this ground alone* I would reject the suggestion that § 188.029 as interpreted is unconstitutional.

Webster, 492 U.S. at 530 (O'Connor, J., concurring) (emphasis added).[10]

10. Although Justice O'Connor's discussion in *Webster* did not end with her analysis under the undue burden standard, it did rely on and adhere to her undue burden approach for abortion regulations. Interpreting Justice O'Connor's opinion as agreeing with the *Akron* strict scrutiny standard for reviewing all abortion regulations would not only be inconsistent with that portion of her opinion that we have quoted in the text, but would also be plainly incompatible with her consistent approach in cases before and after *Webster*: that the undue burden approach is the proper analysis for review of abortion regulations.

We note that Justice O'Connor *herself* has subsequently interpreted her opinion in *Webster* as relying on the undue burden standard. In *Hodgson*, she again put forth the undue burden approach as the proper standard for abortion cases. In doing so, she cited her opinion in *Webster* in support of her understanding that if a regulation does not unduly burden the fundamental right, "then our evaluation is limited to our determination that the regulation rationally relates to a legitimate state purpose." *Hodgson*, 110 S. Ct. at 2949-50 (O'Connor, J., concurring).

Hodgson was decided in a similar manner. There the Court addressed the constitutionality of a two-parent notification requirement without a judicial bypass option and a two-parent notification requirement with a judicial bypass option. Five Justices—Justices O'Connor, Brennan, Marshall, Blackmun, and Stevens—held that a two-parent notification statute without a judicial bypass procedure was unconstitutional. Justice O'Connor found that the regulation caused an

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Moreover, in addition to Justice O'Connor, her colleague read her opinion as we do. Justice Scalia in concurrence in *Webster* interpreted Justice O'Connor's opinion to rely on the undue burden standard in upholding the viability testing provision. He stated: "Justice O'Connor would nevertheless uphold the law because 'it does not impose an undue burden on a woman's abortion decision.'" *Webster*, 492 U.S. at 536 n.* (Scalia, J., concurring).

To understand Justice O'Connor's further discussion in *Webster*, it is necessary to remember that the trimester framework establishes what types of abortion regulations meet the strict scrutiny standard. Under the trimester framework, the state's interest in maternal health is compelling only in the second and third trimesters, and the state's interest in the fetus is compelling only in the third trimester. The plurality in *Webster* found that the viability testing provision was in conflict with the trimester framework. But the plurality upheld the provision after discarding the trimester framework as "unsound in principle and unworkable in practice." Justice O'Connor stated that she continued to have problems with the trimester framework, but she saw no need in *Webster* to address the serious constitutional question raised by its reconsideration. In effect, Justice O'Connor's opinion, after stating why she believed the viability testing provision was constitutional, agreed with the dissent that the plurality was reaching out unnecessarily in addressing the trimester framework.

undue burden and failed to survive strict scrutiny review. She articulated the standard as follows:

> It has been my understanding in this area that "[i]f the particular regulation does not 'unduly burde[n]' the fundamental right, . . . then our evaluation of that regulation is limited to our determination that the regulation rationally relates to a legitimate state purpose." *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 453 (1983) (O'Connor, J., dissenting); see also *Webster v. Reproductive Health Services*, 492 U.S. ___, ___ (1989) (O'Connor, J., concurring in part and concurring in judgment). . . . I agree with Justice Stevens that Minnesota has offered no sufficient justification for its interference with the family's decisionmaking processes created by subdivision 2—two-parent notification.

She gave two reasons why the viability testing provision did not implicate the trimester framework. First, under her approach, it did not cause an undue burden and therefore strict scrutiny and the trimester framework derived from it were simply not applicable. Second, even if the provision triggered strict scrutiny, thus implicating the trimester framework, the Court had always held—consistent with the trimester framework—that the state has a compelling interest in determining the critical point of viability. In sum, according to Justice O'Connor, the trimester framework was neither triggered by nor inconsistent with the viability testing provision.

For our purposes, the most important point about Justice O'Connor's opinion in *Webster* is the following: in arguing that strict scrutiny was not triggered and thus that the trimester framework should not have been reconsidered, Justice O'Connor in no way retreated from, and indeed she affirmatively relied on, her consistent view that a threshold undue burden determination is necessary before strict scrutiny is to be employed.

Hodgson, 110 S. Ct. at 2949-50 (O'Connor, J., concurring). Three of the other four Justices in the majority applied strict scrutiny review without determining as a threshold matter whether the regulation caused an undue burden. Justice Stevens agreed that the statute was unconstitutional, noting that "[u]nder any analysis, the Minnesota statute cannot be sustained if the obstacles it imposes are not reasonably related to legitimate state interests." *Id.* at 2937 (opinion of Stevens, J.). He concluded both that the state had no legitimate interest in assuring that a particular individual parent participate in the child's abortion decision and that requiring the minor to notify both parents did not further the state's interest in seeing that a minor's abortion decision be informed. *Id.* at 2937, 2945. The four dissenters would have applied rational basis review and upheld the provision.

Also in *Hodgson*, five Justices—Justice O'Connor, Chief Justice Rehnquist, and Justices White, Scalia, and Kennedy—held that a two-parent notification requirement with a judicial bypass option was constitutional. Justice O'Connor concluded that it did not cause an undue burden and passed rational basis review:

> In a series of cases, this Court has explicitly approved judicial bypass as a means of tailoring a parental consent provision so as to avoid *unduly burdening* the minor's limited right to obtain an abortion. In *Danforth*, the Court stated that the
>
> > "primary constitutional deficiency lies in [the notification statute's] imposition of an

> > *absolute limitation* on the minor's right to obtain an abortion. . . ."
>
> Subdivision 6 passes constitutional muster because the interference with the internal operation of the family required by subdivision 2 simply does not exist where the minor can avoid notifying one or both parents by use of the bypass procedure.

Hodgson, 110 S. Ct. at 2950-51 (O'Connor, J., concurring) (emphasis added) (citations omitted). The other four Justices in the majority on this issue in *Hodgson* found that the statute passed rational basis review without first deciding if it caused an undue burden. The dissenters would have used strict scrutiny and struck down the provision.

Justice O'Connor thus concurred in *Webster* and on one issue in *Hodgson* by holding that an abortion regulation that imposes no undue burden on a woman's decision to have an abortion does not violate the Due Process Clause so long as it is rationally related to a legitimate state interest. While the views of the other Justices concurring in the judgment on those issues differed from those of Justice O'Connor, all of them would uphold as constitutional any regulation meeting that standard.

Moreover, Justice O'Connor concurred in the Court's judgment on the other issue in *Hodgson* on the ground that an abortion regulation that imposes an undue burden on the decision to abort violates the Due Process Clause if does not meet the strict scrutiny standard. Here also, the other Justices concurring in the judgment on this issue did not join her opinion, but they would strike

down as unconstitutional any regulations struck down under the undue burden standard.

In these circumstances, we conclude that it would be inconsistent with the teachings of *Marks* for lower courts to apply the strict scrutiny test of *Roe*, *Akron*, and *Thornburgh* to all abortion regulations. We also conclude that only by applying the undue burden standard of review, that is, only by applying strict scrutiny review to regulations that impose an undue burden and rational basis review to those which do not, can we remain faithful to *Marks*. Only by following the rationale of Justice O'Connor's concurring opinions will the lower courts decide abortion regulation cases in a way consistent with the way the Court decided them in *Webster* and *Hodgson*.

4.

Having concluded that the undue burden standard is binding on us, one issue of *stare decisis* remains: Are we required to follow *results* reached by the Supreme Court in cases prior to *Webster* and *Hodgson* even though we are not bound by the rationale which produced those results? In the instant case, this issue is relevant because the Supreme Court, engaging in strict scrutiny review in *Akron* and *Thornburgh*, struck down informed consent provisions almost identical to the provisions at issue here. If we were constrained to follow the *results* reached in *Akron* and *Thornburgh*, we would hold unconstitutional the informed consent provisions of the Pennsylvania Act. We are convinced, however, that such a course would be improper.

It would be anomalous if the results reached under a constitutional standard remained binding

after the standard or test was repudiated. To take a variation[11] of a familiar constitutional story, suppose that the Court in *Brown v. Board of Education*, 347 U.S. 483 (1954), had required that states no longer run segregated school systems by repudiating the *Plessy* separate but equal doctrine and stating that the Equal Protection Clause forbids invidious racial classifications by government. Although *Brown* of course involved schools, a lower court in the aftermath would apply that principle to all racial classifications by government, regardless of whether before *Brown* the Supreme Court had upheld racial classifications in the particular context at issue. Thus, if pre-*Brown*, the Court had stated that state-segregated public pools did not violate the Equal Protection Clause, a lower court faced with a challenge to state-segregated pools after the *Brown* decision would apply the new principle to pools rather than upholding the segregated pools on the basis of the result reached by the Supreme Court under the discarded standard.

In order to change course in a particular area, it simply is unnecessary for the Supreme Court to go case-by-case through fact patterns that the Court had previously addressed under a repudiated standard. If the standard is replaced, decisions reached under the old standard are not

11. We say variation because the Court in *Brown* actually seemed to rest its decision on the context—schools—rather than a blanket principle about the Equal Protection Clause. For our example here, we will assume that the latter had occurred.

binding.[12] We thus conclude that a change in the legal test or standard governing a particular area is a change binding on lower courts that makes results reached under a repudiated legal standard no longer binding.[13]

In sum, Justice O'Connor's undue burden standard is the law of the land, and we will apply that standard to all provisions of the Pennsylvania Act at issue in this appeal.

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12. While results reached under a discarded standard are no longer binding, that does not mean that the old results are necessarily wrong; it simply means that the fact patterns producing those results must be analyzed under the new standard. That is why, though we conclude that the strict scrutiny standard applied in *Akron* and *Thornburgh* is no longer governing and the results no longer binding, the provisions held unconstitutional there are not necessarily constitutional; we must instead analyze the provisions under the newly minted undue burden standard.

13. We are of course mindful that only the Supreme Court "may overrule one of its precedents." *Thurston Motor Lines v. Jordan K. Rand Ltd.*, 460 U.S. 533, 535 (1983); *Rodriguez de Quijas v. Shearson/American Express, Inc.*, 490 U.S. 477 (1989). The Court rejected anticipatory overruling in *Rodriguez*: A lower court may not disregard a result reached under a controlling standard, even when that result is inconsistent with other results reached under the same standard. Similarly, a lower court may not reject a governing standard unless a majority of the Justices in a single case declines to apply it. Thus, while a regulation must constitute an undue burden to trigger strict scrutiny, the trimester framework is still binding when strict scrutiny is triggered. Although five sitting Justices of the Supreme Court have criticized or rejected the *Roe* trimester framework, they have not rejected it in a single case. *Cf. Sojourner v. Roemer*, Nos. 91-2247, 91-2422 (E.D. La. Aug. 7, 1991) (invalidating criminal prohibition on abortion).

III.

An abortion regulation can infringe upon the abortion right in at least seven ways: (1) causing a delay before the abortion is performed; (2) raising the monetary cost of an abortion; (3) reducing the availability of an abortion by directly or indirectly causing a decrease in the number of legal abortion providers; (4) causing or forcing the woman to receive information she has not sought; (5) causing the woman to find the person or persons whom the state has required that she notify or obtain consent from; (6) causing the woman to endure any negative or hostile response from a person whom the state has required the woman to notify or obtain consent from; and (7) taking away the power to decide whether to have an abortion by giving another person, usually a parent or spouse, a veto power on the abortion decision. Almost all abortion regulations implicate the first three of these; informed consent requirements also involve the fourth; and notice and consent statutes also implicate the fifth, sixth, and seventh.

A review of the abortion case law, and *Webster* and *Hodgson* in particular, suggest that no undue burden is caused by abortion regulations that do not have a "severe" or "drastic" impact upon time, cost, or the number of legal providers of abortions. *Webster*, 492 U.S. at 529-30 (O'Connor, J., concurring); *Thornburgh*, 476 U.S. at 827-33 (O'Connor, J., dissenting); *Akron*, 462 U.S. at 464-67, 472-74 (O'Connor, J., dissenting). Similarly, the case law indicates that a state's requirement that abortion providers communicate information to a woman, which is typically in the form of an informed consent requirement, will not

constitute an undue burden if the information that the abortion provider must give is relevant, accurate, and non-inflammatory. *Thornburgh*, 476 U.S. at 830-32 (O'Connor, J., dissenting).[14]

The primary manner in which an abortion regulation can constitute an undue burden, other than by banning some or all previability abortions, is by taking away the woman's unilateral power to decide whether to have a previability abortion. Thus, a regulation in which the state gives a veto power to the woman's husband or, for a minor woman, to a parent constitutes an undue burden. *See Hodgson*, 110 S. Ct. at 2949-50 (O'Connor, J., concurring); *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting); *Bellotti II*, 443 U.S. at 646-48; *Danforth*, 428 U.S. at 67-72. However, a parental consent or notice provision combined with an adequate judicial bypass procedure does not constitute an undue burden. *See Hodgson*, 110 S. Ct. at 2950-51 (O'Connor, J., concurring).

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14. We have held that the undue burden standard adopted by Justice O'Connor in *Webster* and *Hodgson* is the binding standard. The definition of that standard—"absolute obstacle or severe limitation"—used by Justice O'Connor in those cases is binding, as is her application of that standard to the viability testing provision and two-parent notification provision. However, her application of that standard in past dissents—the results she would have reached in those cases—is not binding on us. Nonetheless, we will often refer to her application of the undue burden standard in past dissents as evidence (though not conclusive) of how the undue burden standard might apply here. As we stated earlier, lower courts cannot read the tea leaves in overruling precedent, but lower courts can do so with respect to open issues or new areas; and that, in effect, is what we confront here, since for most of the provisions involved in this case, the Court has never applied the undue burden standard.

With this overall orientation, we turn now to the individual provisions of the Act. We may overrule the district court's factual findings based on the evidence before it only when clearly erroneous. We exercise plenary review, however, over the district court's determination of constitutionality and thus over whether the facts found regarding the effect of a particular statutory provision constitute an "undue burden." We also exercise plenary review over the question whether a provision passes strict scrutiny or rational basis review.

A. *The Medical Emergency Exception*

We first address an issue that would affect virtually all of our later analysis if not resolved at the outset. Section 3203 of the Act defines the term medical emergency. A medical emergency is:

> that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function.

18 Pa. Cons. Stat. Ann. § 3203 (1983 & Supp. 1991). When a medical emergency exists, the Act permits doctors and women to forego a number of the Act's requirements, including the waiting period, parental consent, and spousal notice requirements. The district court declared the definition in § 3203 unconstitutionally narrow and struck down all provisions of the Act that contained this medical emergency exception: for certain

provisions, this was only an alternative basis for the district court's holding of unconstitutionality.

The Supreme Court indicated in *Roe* and subsequent cases that the state's interest in the fetus is not sufficient to prevent a woman: (1) from having a previability abortion; or (2) from having an abortion at any point during the pregnancy, immediately if necessary, to prevent a serious threat to her life or health. In *Roe*, the Court stated that third trimester abortions may be banned except where "necessary to preserve the life *or health* of the mother." 410 U.S. at 164 (emphasis added); *see also Harris v. McRae*, 448 U.S. 297, 316 (1980) ("It could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in [*Roe*]."). From *Roe* and subsequent cases, it thus appears that any abortion regulation which might delay or prevent an abortion must contain a medical emergency exception.

The Commonwealth does not dispute that its abortion regulations would be constitutionally deficient if they did not contain an exception for those situations in which compliance would pose a serious risk to the life or health of the woman. The clinics acknowledge that the Act's medical emergency exception is intended to protect the life and health of the woman, but they seek to demonstrate that it is deficient by pointing to three conditions encountered by pregnant women with some frequency: preeclampsia, inevitable abortion, and prematurely ruptured membrane. In the clinics' view, these conditions are not covered by the medical emergency exception because each

"could pose a serious threat to a woman's health without immediately creating a serious risk of substantial and irreversible impairment to a major bodily function." Brief for Appellees at 16. The clinics insist that this renders the Commonwealth's regulations unconstitutional.

The Commonwealth does not challenge the assertion that its regulations would be unconstitutional if women having preeclampsia, inevitable abortion, or prematurely ruptured membrane were required to satisfy all of the requirements of the Act before having an abortion. Rather, the Commonwealth responds that preeclampsia, inevitable abortion, and prematurely ruptured membrane are "medical emergencies" as defined in the Act because "all of these conditions, if left untreated, could progress to such a point that death or substantial and irreversible impairment of a major bodily function will occur." Reply Brief for Appellants at 4 n.2.

It is thus apparent that our initial issue for resolution is one of statutory interpretation and is governed by Pennsylvania law. There is no helpful Pennnsylvania case law construing the medical emergency provision of the Act. There are, however, Pennsylvania cases indicating that statutes of the Commonwealth should be construed to sustain their constitutionality. *See Commonwealth v. Blystone*, 549 A.2d 81, 87 (Pa. 1988) ("Any doubts are to be resolved in favor of sustaining the legislation."); *Hughes v. Commonwealth Dept. of Transportation*, 523 A.2d 747, 750-51 (Pa. 1987) ("We must presume that an Act of the legislature is intended to be constitutional and wherever a legislative act can be preserved from unconstitutionality it must be

preserved."); *see also Webster*, 492 U.S. at 514 (statutes should be interpreted to avoid constitutional difficulty); *Frisby v. Schultz*, 487 U.S. 474, 483 (1988) (same). With this case law in mind, we turn to the symptoms and the risks of each of the conditions identified by the clinics.

Preeclampsia is a combination of symptoms related to an immunological disorder. When diagnosed as having preeclampsia, "the patient develops hypertension, she can have destruction of the liver, hemorrhage into the liver, she can have destruction of the kidneys and she may go on to have clampsia, which is a seizure disorder of the brain." Trial Testimony of Dr. Bolognese, Witness for the Clinics ("Bolognese Testimony"), App. at 614. Both Dr. Bolognese for the clinics and the doctor who testified for the Commonwealth agreed that preeclampsia requires an abortion. Trial Testimony of Dr. Bowes, Witness for the Commonwealth ("Bowes Testimony"), App. at 889.

The symptoms of inevitable abortion are bleeding from the uterus and cramps in the lower abdominal area. The failure to terminate the pregnancy immediately when this condition exists can lead to extensive blood loss, shock, infection, and, if there is serious hemorrhaging and shock, even death. 744 F. Supp. at 1346-47. The Commonwealth's expert at trial agreed with the clinics' expert that the universally recommended treatment of an inevitable abortion is immediate termination of the pregnancy. Bowes Testimony, App. at 888.

The major risk from a prematurely ruptured membrane is that an infection will occur. If an infection occurs, a woman can be exposed to spread of the infection, an overwhelming septic

infection, hemorrhaging, shock, and even death. Bolognese Testimony, App. at 611.

There is no dispute between the parties that preeclampsia, inevitable abortion and prematurely ruptured membrane *can lead to* a substantial and irreversible impairment of a major bodily function. The record is clear that a failure to obtain an abortion when a woman is diagnosed with preeclampsia can lead to irreversible damage to the liver, kidneys and more; that failure to perform an abortion when a woman is diagnosed with inevitable abortion can eventually lead to death; and that a failure to obtain an abortion when a woman is diagnosed with prematurely ruptured membrane can eventually lead to death. The dispute between the parties concerns the meaning of the phrase "serious risk." The Commonwealth insists that whenever these conditions exist, there is a "serious risk" of substantial and irreversible impairment of a major bodily function. The clinics argue that no such "serious risk" exists until the woman has actually experienced shock or contracted an infection. We conclude that the clinics' interpretation is unduly restrictive.

The word "risk" necessarily implies an event that may or may not happen in the future. Neither "risk" nor the addition of the adjective "serious" implies that the probability assessed is the probability of the hypothesized event occurring immediately following the time of assessment. Accordingly, we do not believe the risk that prematurely ruptured membrane, if untreated, will lead to substantial and irreversible injury only after progressing through shock or infection necessarily means that there is no "serious risk" at the onset of the condition. We assume that the

risk of substantial and irreparable impairment of a major bodily function will be quantitatively less at the onset of a prematurely ruptured membrane than after shock has occurred, but this does not mean the risk at onset is not "serious."

The Pennsylvania legislature did not choose the wording of its medical emergency exception in a vacuum, and we do not believe the words chosen should be interpreted in one. In the case of all three conditions pointed to by the clinics, the treatment uniformly prescribed by the medical profession at the time of the legislature's choice was an immediate abortion. This was the recommended treatment in all pregnancies in which these conditions arose, including planned and desired pregnancies. This medical consensus that the risk occasioned is sufficiently serious to call for an immediate abortion was a part of the context in which the medical emergency provision was fashioned.

Moreover, we read the medical emergency exception as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman. We believe it should be interpreted with that objective in mind. While the wording seems to us carefully chosen to prevent negligible risks to life or health or significant risks of only transient health problems from serving as an excuse for noncompliance, we decline to construe "serious" as intended to deny a woman the uniformly recommended treatment for a condition that can lead to death or permanent injury.

The essence of the definition in § 3203 is that it allows a woman and her doctors to forego many

of the Act's requirements when there is a medical emergency to the woman's physical health, and that includes where a woman has symptoms of preeclampsia, inevitable abortion, or prematurely ruptured membrane. We interpret § 3203 to allow women and doctors to forego the Act's requirements when a woman is diagnosed as having one of these conditions. If the Commonwealth were to choose, in contradiction to its representations to this court, to prevent doctors and women from foregoing the Act's requirements when a woman has been so diagnosed, that application would almost certainly be unconstitutional under present Supreme Court law.

Any doubt on our interpretation of § 3203 is resolved by the procedural posture of the case. This is a facial challenge. The Supreme Court has instructed on numerous occasions that a court is not to strike down a law as unconstitutional on the basis of "a worst-case analysis that may never occur." *Ohio*, 110 S. Ct. at 2981. The Supreme Court recently applied this principle in a very similar context in *Rust v. Sullivan*, 111 S. Ct. 1759 (1991). There, the regulations at issue did not contain an explicit exception for cases where a woman's pregnancy placed her life in imminent peril, but the Court rejected a facial claim that the regulations would not allow abortion referral in such circumstances. The Court stated that on a facial challenge without "any application by the Secretary to a specific fact situation," it would not read the regulations to bar referral in such cases. *Id.* at 1773. Similarly presented with a facial challenge, we uphold the medical emergency exception defined in § 3203.

In an alternative challenge, the clinics argue that the medical emergency definition is void for vagueness. The district court did not consider this issue; we do so here and reject it. The Act provides criminal and civil sanctions against doctors who violate the Act's provisions. However, the Act allows doctors and women to forego the Act's requirements when, "on the basis of the physician's good faith clinical judgment," a condition exists that meets the definition of medical emergency in § 3203. The Commonwealth argues that the terms of § 3203 are not vague. They also contend that the subjective standard of "good faith clinical judgment" saves the statute from any problem of vagueness.

In *United States v. Vuitch*, 402 U.S. 62, 69-72 (1971), the Supreme Court upheld against a vagueness challenge a requirement that an abortion be "necessary for the preservation of the mother's life or health." In *Doe v. Bolton*, the Court upheld against a vagueness challenge a requirement that the physician determine, on the basis of his or her "best clinical judgment," that an abortion is "necessary." 410 U.S. at 191-92. In contrast, in *Colautti v. Franklin*, 439 U.S. 379, 390-97 (1979), the Court struck down on vagueness grounds a requirement that the physician determine if the fetus "is viable" or "may be viable" before performing an abortion. The Court stated that it was unclear whether the Act incorporated a subjective or objective standard. In addition, the definition of "may be viable" was elusive and did not provide sufficient notice.

In this case, the statute requires a physician to violate his or her own good faith clinical judgment in order to be criminally liable. This is a

subjective, not an objective standard, thus making the case more similar to *Vuitch* and *Doe* than to *Colautti*. We fail to see how any physician practicing in good faith could fear conviction under the Act.

Moreover, as we have already concluded, the language of § 3203, apart from the "good faith clinical judgment" language, does not prohibit doctors from foregoing the Act's requirements when what are commonly perceived to be medical emergencies exist. The clinics here came up with three medical emergencies that they argued were not covered by the statute. We have held that they are. Physically threatening emergencies are covered; determining whether, in a physician's good faith clinical judgment, one of those emergencies is present is the type of "judgment[] that physicians are obviously called upon to make routinely whenever surgery is considered." *Doe*, 410 U.S. at 192. Section 3203 provides the fair warning required by the Due Process Clause; it is not void for vagueness.

B. *The Informed Consent Requirement*

Section 3205(a) contains the informed consent provisions of the Act. Three aspects of that section are at issue in this appeal: two information disclosure requirements and a requirement that the woman wait 24 hours between the time she receives this information and the time the abortion is performed.[15] We address these provisions in turn.

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15. Section 3205 of the Act states in relevant part:

1. *Physician-Disclosed Information*

Section 3205(a)(1) requires that the referring or performing physician inform a woman contemplating an abortion of: (i) the nature of the abortion procedure and of those risks and

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(a) GENERAL RULE.– No abortion shall be performed or induced except with the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Except in the case of a medical emergency, consent to an abortion is voluntary and informed if and only if:

(1) At least 24 hours prior to the abortion, the physician who is to perform the abortion or the referring physician has orally informed the woman of:

(i) The nature of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(ii) The probable gestational age of the unborn child at the time the abortion is to be performed.

(iii) The medical risks associated with carrying her child to term.

(2) At least 24 hours prior to the abortion, the physician who is to perform the abortion or the referring physician, or a qualified physician assistant, health care practitioner, technician or social worker to whom the responsibility has been delegated by either physician, has informed the pregnant woman that:

(i) The department [Pennsylvania Department of Health] publishes printed materials which describe the unborn child and list agencies which offer alternatives to abortion and that she has a right to review the printed materials and that a copy will be provided to her free of charge if she chooses to review it.

(ii) Medical assistance benefits may be available for prenatal care, childbirth and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials published by the department.

alternatives to the procedure or treatment that a reasonable patient would consider material to the

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(iii) The father of the unborn child is liable to assist in the support of her child, even in instances where he has offered to pay for the abortion. In the case of rape, this information may be omitted.

(3) A copy of the printed materials has been provided to the woman if she chooses to view these materials.

(4) The pregnant woman certifies in writing, prior to the abortion, that the information required to be provided under paragraphs (1), (2) and (3) has been provided.

(b) EMERGENCY.– Where a medical emergency compels the performance of an abortion, the physician shall inform the woman, prior to the abortion if possible, of the medical indications supporting his judgment that an abortion is necessary to avert her death or to avert substantial and irreversible impairment of major bodily function.

(c) PENALTY.– Any physician who violates the provisions of this section is guilty of "unprofessional conduct" and his license for the practice of medicine and surgery shall be subject to suspension or revocation . . . . Any physician who performs or induces an abortion without first obtaining the certification required by subsection (a)(4) or with knowledge or reason to know that the informed consent of the woman has not been obtained shall for the first offense be guilty of a summary offense and for each subsequent offense be guilty of a misdeameanor for the third degree. No physician shall be guilty of violating this section for failure to furnish the information required by subsection (a) if he or she can demonstrate, by a preponderance of the evidence, that he or she reasonably believed that furnishing the information would have resulted in a severely adverse effect on the physicial or mental health of the patient.

(D) LIMITATION ON CIVIL LIABILITY.– Any physician who complies with the provisions of this section may not be held civilly liable to his patient for failure to obtain informed consent to the abortion within the meaning of that term as defined by the act of October 15, 1975 (P.L. 390, No. 111), known as the Health Care Services Malpractice Act.

decision whether or not to obtain an abortion; (ii) the probable gestational age of the fetus; and (iii) the medical risks associated with carrying a child to term. Such a provision can be expected to cause four types of burdens: time delay, higher cost, reduced availability, and forcing the woman to receive information she has not sought. We conclude, however, that none of these potential burdens can be characterized as an undue burden.

The time required to provide medical risk information of this kind is acknowledged to be insignificant. While the district court found that higher costs would be occasioned by § 3205(a)(1)'s requirement that physicians rather than counselors provide this information, the district court did not quantify the increase, and this record would not support a finding of an increase of sufficient size to constitute an absolute obstacle or severe limitation on the abortion right. *See Webster*, 492 U.S. at 530 (O'Connor, J., concurring); *Akron*, 462 U.S. at 467, 473 (O'Connor, J., dissenting). Similarly, this requirement will not cause abortion providers to stop providing any or all abortions and, accordingly, will not cause a drastic or severe reduction in the availability of abortion. Finally, the information provided is accurate and necessary for a woman to make an assessment for her abortion decision. Indeed, the record shows that the clinics, without exception, insist on providing this information to women before an abortion is performed. Thus, the "burden" of forcing a woman to listen to it is not an absolute obstacle or severe limitation. In sum, we agree with Justice O'Connor's characterization of nearly identical requirements in *Akron*: such requirements "impose

no undue burden or drastic limitation on the abortion decision." *Akron*, 462 U.S. at 472 (O'Connor, J., dissenting).

We also have no difficulty concluding that § 3205(a)(1) is rationally related to a legitimate state interest. In *Akron*, all nine Justices agreed that the state may require a woman contemplating an abortion to receive information about the nature and risks of the abortion procedure. This type of information "clearly is related to maternal health and to the State's legitimate purpose in requiring informed consent." *Akron*, 462 U.S. at 446. The Court in *Akron* also found that the state has a legitimate interest in requiring that an abortion provider inform the woman of the probable gestational age of the fetus. Finally, there is nothing irrational about a requirement that the provider inform the woman of the medical risks of carrying the pregnancy to term since this is obviously the only medical alternative to abortion. *See Thornburgh*, 476 U.S. at 830 (O'Connor, J., dissenting) (such a requirement provides "the kind of balanced information I would have thought all could agree is relevant to a woman's informed consent").[16]

Turning from the content of the required advice to the manner of its presentation, we think it patent that a state may rationally decide that physicians are better qualified than counselors to

16. The district court stressed that a woman who has decided upon an abortion has no need to know about the risk of carrying to term. This misses what we perceive to be the relevant point. The state may rationally require that a woman not move forward on a decision to abort without evaluating that decision on an informed basis.

impart this information and answer questions about the medical aspects of the available alternatives. While the record contains evidence that counselors at the clinics are often capable of informing women about the abortion procedure, that is not the issue; the issue is whether the state may rationally conclude that physicians as a class are better equipped to provide such medical information and answer questions about the abortion procedure and the alternative. We believe the Commonwealth could rationally so conclude and, accordingly, that § 3205(a)(1) is a constitutionally valid regulation. *Cf. Williamson v. Lee Optical*, 348 U.S. 483, 487 (1955).

2. *Counselor-Disclosed Information*

Section 3205(a)(2) requires that a physician or counselor ("any qualified agent of the physician") inform a woman: (i) that medical assistance benefits may be available for prenatal, childbirth, and neonatal care and that more information about the benefits is available in state-printed materials; (ii) that the father of the child is liable to assist in support of the child (this information is not required to be given in rape cases); and (iii) that the Pennsylvania Department of Health publishes printed materials which describe the fetus at various intervals and list agencies which offer alternatives to abortion and that such materials are available free of charge.[17] Applying the threshold undue burden standard, we conclude that this provision does not cause an undue burden; in addition, we find it rationally

17. Section 3205(a)(3) requires that a copy of these printed materials be available if the woman chooses to see them.

related to a legitimate state interest. Therefore, we uphold it against the clinics' challenge.

Once again, the time required to provide the required information is minimal. While requiring that a physician or counselor impart this information will add some cost to the pre-abortion procedure at those clinics that do not already provide options counseling, nothing in the record suggests that the increase will be drastic or even substantial. Similarly, there is no evidence that any abortion provider will stop providing abortions because of this requirement. Indeed, the record indicates that most clinics already require that a counselor consult in person with the woman about alternatives to abortion before the abortion is performed.

Justice O'Connor stated in *Thornburgh* that informed consent requirements could constitute an undue burden if the information required to be given was irrelevant, inaccurate, or inflammatory. *See Thornburgh*, 476 U.S. at 830-31 (O'Connor, J., dissenting). The information that § 3205 requires a physician or counselor to impart is relevant, accurate, and non-inflammatory. The information regarding the financial assistance to which the woman may be entitled is relevant in that it provides a woman with information necessary to make an informed choice. There is nothing on the face of the statute that suggests that this information is inaccurate. Nor do we see any threat that such information is inflammatory. Moreover, the printed materials concerning the fetus and alternatives to abortion are not forced on the woman; the woman is merely told that such information is available to her if she desires it. As Justice O'Connor stated in *Thornburgh*, "If the

materials were sufficiently inflammatory and inaccurate the fact that the woman must ask to see them would not necessarily preclude finding an undue burden, but there is no indication that this is true of the description of fetal characteristics [or alternatives to abortion] the statute contemplates." *Id.* at 831 (O'Connor, J., dissenting). For these reasons, we conclude that this provision causes nowhere near the kind of burden that must result for a regulation to constitute an undue burden.

We further conclude that this provision is rationally related to a legitimate state interest. *Roe* recognized that the state has a legitimate interest in the potential life of the fetus throughout pregnancy, and a state may rationally conclude that this interest will be served by assuring that a pregnant woman have knowledge of the resources available to her should she elect to carry to term.

3. *First Amendment Implications of Section 3205(a)*

The clinics claim that § 3205(a) requires that a physician or counselor act as an instrument for the dissemination of an ideological message in violation of their First Amendment rights. We find the argument unpersuasive.

This case involves commercial speech, and the clinics do not dispute this point. The First Amendment limits on compelled disclosure requirements for commercial speech were explained by the Court in *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985).[18] There,

18. The clinics' reliance on *Riley v. National Federation for the Blind*, 487 U.S. 781 (1988), is misplaced. The Court there distinguished its case, which did not involve commercial speech, from other cases, and stated that "[p]urely commercial speech is more susceptible to compelled disclosure requirements." *Id.* at 796 n.9.

the Court rejected an attorney's challenge to a state requirement that he include certain information in an advertisement. The Court stressed that the attorney overlooked "material differences between disclosure requirements and outright prohibitions on speech." *Id.* at 650. Disclosure requirements are permissible so long as they are not a state attempt to prescribe what is "orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein." *Id.* at 651. The Court then held that First Amendment rights "are adequately protected so long as disclosure requirements are reasonably related to the state's interest in preventing deception of consumers." *Id.*

Here, none of the information that § 3205 requires that physicians and counselors provide, including the information offered in the printed materials, has been shown to be false or unverifiable. It is not an attempt to prescribe an orthodoxy in matters of opinion, and the information involved is reasonably related to the state's interest in ensuring that women have relevant information before having an abortion.[19]

19. The disclosure required by the Pennsylvania Act is similar to a long list of regulations by state and federal governments designed to protect the public. For example, the federal government requires warnings on all cigarette packages, advertisements, and billboards. 15 U.S.C. § 1333 (1988). Federal law requires disclosure in the context of securities transactions. 15 U.S.C. § 78(b) (1988). Pennsylvania requires

We thus hold that the informed consent requirements do not violate the First Amendment.

4. *The 24-Hour Waiting Period*

Section 3205(a) of the Act requires a mandatory 24-hour waiting period between the time that the physician and counselor provide the required information to a woman and the time that a physician performs the abortion. The woman's consent to the abortion may be given at any time during that period, including right before the abortion.

As the clinics stress, a 24-hour waiting period may result in delays considerably longer than 24 hours because most clinics do not perform abortions every day of the week. Moreover, such a waiting period may require a woman to make two visits to a clinic rather than one. Where the woman has no clinic immediately available and must travel to obtain an abortion, this means that the overall cost of an abortion to her may increase by a significant percentage. And as the district court pointed out, the burden of an additional trip to the clinic falls most heavily on battered wives who often find it difficult to free themselves of their husband's surveillance.

financial institutions to disclose rates, terms, definitions, and other information in residential mortgage applications. 41 Pa. Cons. Stat. Ann. § 301(e) (Supp. 1991).

The clinics' argument is potentially limitless: there is "no reason why a concern for professional freedom could be confined to the medical profession; nothing in the Constitution indicates a preference for the liberty of doctors over that of lawyers, accountants, bakers, or brickmakers." *Thornburgh*, 476 U.S. at 802-03 (White, J., dissenting). Thus, if this provision violated the First Amendment, the above-cited disclosure requirements would presumably also have to fall.

Despite these adverse consequences from the 24-hour waiting period, however, we conclude that this requirement does not constitute an undue burden. In *Hodgson*, the Supreme Court concluded that a two-parent notification requirement with a judicial bypass was rationally related to a legitimate state interest and, therefore, was constitutional. Justice O'Connor noted that the Court had "explicitly approved judicial bypass as a means of tailoring a parental consent provision so as to avoid unduly burdening the minor's limited right to obtain an abortion." *Hodgson*, 110 S. Ct. at 2950 (O'Connor, J., concurring). The Court reached this conclusion despite the trial court's findings that "scheduling practices in Minnesota courts typically require minors to wait two or three days between their first contact with the court and the hearing on their petitions" and that this delay "may combine with other facts to result in a delay of a week or more." 648 F. Supp. at 853.

Given the Court's conclusion in *Hodgson* that the length of the delays and the increased costs occasioned by the judicial bypass did not impose an undue burden on the right to an abortion or otherwise require strict scrutiny, we decline to reach a different result with respect to the Commonwealth's imposition of a 24-hour delay for considering the information required by the informed consent requirements.[20]

20. In *Akron*, the Supreme Court invalidated an Ohio statute that required a 24-hour delay so that the "woman's decision [would] be informed." 462 U.S. at 450. The Court reached this result applying strict scrutiny, however, and as we have explained, we are not bound by the result in *Akron* if, as we conclude, the Commonwealth's 24-hour waiting period imposes no undue burden. While Justices Stevens and

Accordingly, we now inquire whether the 24-hour waiting period passes rational basis.[21] All parties agree that choosing to have an abortion is an important decision. The state's interest in ensuring that such a decision is *both* informed *and* well-considered is rationally related to the state's legitimate interest in the life and health of the mother as well as its interest in the potential life of the fetus. The waiting period "reasonably relates to the State's interest in ensuring that a woman does not make this serious decision in undue haste." *Akron*, 462 U.S. at 474 (O'Connor, J., dissenting).

O'Connor in *Hodgson* viewed *Akron*'s 24-hour waiting period for an adult as less justified by the state's interest than a 48-hour waiting period for a minor after notification of a parent. 110 S. Ct. at 2944 n.35. nothing said in *Hodgson* suggests to us that the Commonwealth's 24-hour waiting period is an undue burden. As Justice O'Connor stressed in *Hodgson*, the Court has consistently viewed judicial bypass provisions as a means of avoiding an undue burden and, it necessarily follows that the time required to pursue such a bypass cannot constitute one. That time varies depending on the statute involved, but necessarily involves at least several days. The judicial bypass approved in *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 477 n.4, 491 n.16 (1983), could require 17 calendar days; the bypass approved in *Ohio v. Akron Center for Reproductive Health*, 110 S. Ct. 2972, 2980-81 (1990), could require 14 days.

21. The Court in *Akron* in striking down a similar 24-hour waiting period occasionally used language similar to that of rational basis review in considering the relationship between a waiting period and maternal health. However, we believe that the Court's level of review in *Akron* for all abortion regulations was strict scrutiny. *See Akron*, 462 U.S. at 428-31 (outlining *Roe* standard); *Hodgson*, 110 S. Ct. at 2952 (Marshall, J., dissenting) (citing *Akron* in stating, "we have subjected state laws limiting that right to the most exacting scrutiny, requiring a State to show that such a law is narrowly drawn to serve a compelling state interest").

In sum, we believe the waiting period is "a small cost to impose to ensure that a woman's decision is well considered in light of its certain and irreparable consequences on fetal life, and the possible effects on her own." *Akron*, 462 U.S. at 474 (O'Connor, J., dissenting). We fully recognize that many women contemplating an abortion will have seriously considered their decision before the required consultations with physician and counselor take place. The waiting period may not for those women serve any purpose. But the wait does not prevent any women from having an abortion, and the possible overinclusiveness of the provision does not render it irrational, especially given the serious and irreversible consequences of a hasty and ill-considered abortion decision.

C. Parental Consent with Judicial Bypass

For women under 18 who desire an abortion, § 3206 of the Act requires the informed consent of at least one parent, but provides a judicial bypass option if a woman does not wish to or cannot obtain a parent's consent.[22]

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22. Section 3206 of the Act provides in part:

(a) GENERAL RULE.—Except in the case of a medical emergency, or except as provided in this section, if a pregnant woman is less than 18 years of age and not emancipated, or if she has been adjudged an incompetent . . ., a physician shall not perform an abortion upon her unless, in the case of a woman who is less than 18 years of age, he first obtains the informed consent both of the pregnant woman and of one of her parents; or, in the case of a woman who is incompetent, he first obtains the informed consent of her guardian.

. . .

(c) PETITION TO COURT FOR CONSENT.—If both of the parents or guardians of the pregnant woman refuse to consent to the performance of an abortion or if she elects not to seek the consent of either of her parents or of her guardian,

An absolute parental consent requirement with no exceptions would cause an undue burden on a

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the court of common pleas of the judicial district in which the applicant resides or in which the abortion is sought shall, upon petition or motion, after an appropriate hearing, authorize a physician to perform the abortion if the court determines that the pregnant woman is mature and capable of giving informed consent to the proposed abortion, and has, in fact, given such consent.

(d) COURT ORDER.—If the court determines that the pregnant woman is not mature and capable of giving informed consent or if the pregnant woman does not claim to be mature and capable of giving informed consent, the court shall determine whether the performance of an abortion upon her would be in her best interests. If the court determines that the performance of an abortion would be in the best interests of the woman, it shall authorize a physician to perform the abortion.

. . .

(f) PROCEEDINGS.—

(1) Court proceedings under this section shall be confidential and shall be given such precedence over other pending matters as will ensure that the court may reach a decision promptly and without delay in order to serve the best interests of the pregnant woman. In no case shall the court of common pleas fail to rule within three business days of the date of application. A court of common pleas which conducts proceedings under this section shall make in writing specific factual findings and legal conclusions supporting its decision and shall, upon the initial filing of the minor's petition for judicial authorization of an abortion, order a sealed record of the petition, pleadings, submissions, transcripts, exhibits, orders, evidence and any other written material to be maintained which shall include its own findings and conclusions.

. . .

(3) The name of the pregnant woman shall not be entered on any docket which is subject to public inspection. All persons shall be excluded from hearings under this section except the applicant and such other persons whose presence is specifically requested by the applicant or her guardian.

minor woman's abortion decision because it would impose an absolute veto and take the decisionmaking power from the woman contemplating an abortion. *Cf. Hodgson*, 110 S. Ct. at 2949-50 (O'Connor, J., concurring); *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting). The Pennsylvania statute, however, provides a judicial bypass option, and the Supreme Court, including Justice O'Connor, has consistently held that any undue burden caused by a parental notification or consent statute is alleviated if it provides a judicial bypass option that comports with the requirements outlined in *Bellotti v. Baird*, 443 U.S. 622, 663-64 (1979) ("*Bellotti II*"). *See Hodgson*, 110 S. Ct. at 2950-51 (O'Connor, J., concurring); *id.* at 2970 (opinion of Kennedy, J.); *Ohio*, 110 S. Ct. at 2978-81; *see also Planned Parenthood v. Miller*, 934 F.2d 1462, 1475-82 (11th Cir. 1991). Thus, so long as an adequate judicial bypass procedure existed, the Court has upheld many different forms of parental consent and parental notification laws.

. . .

(h) REGULATION OF PROCEEDINGS.—

. . . Any court to which an appeal is taken under this section shall give prompt and confidential attention thereto and shall rule thereon within five business days of the filing of the appeal.

. . .

(i) PENALTY.—Any person who performs an abortion upon a woman who is an unemancipated minor or incompetent to whom this section applies either with knowledge that she is a minor or incompetent to whom this section applies, or with reckless disregard or negligence as to whether she is a minor or incompetent to whom this section applies, and who intentionally, knowingly or recklessly fails to conform to any requirement of this section is guilty of "unprofessional conduct" and his license for the practice of medicine and surgery shall be suspended . . . for a period of at least three months.

including two-parent consent and two-parent notification. *See Bellotti II*, 443 U.S. at 643 ("We therefore conclude that if the State decides to require a pregnant minor to obtain one or both parents' consent to an abortion, it also must provide an alternative procedure whereby authorization for the abortion can be obtained."); *Hodgson*, 110 S. Ct. at 2970 (opinion of Kennedy, J.) ("The simple fact is that our decision in *Bellotti II* stands for the proposition that a two-parent consent law is constitutional if it provides for a sufficient judicial bypass alternative.").[23]

Bellotti II set out the constitutional requirements for a bypass procedure that the Court has followed in a number of subsequent cases:

> A pregnant minor is entitled in such a proceeding to show either: (1) that she is mature enough and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents' wishes; or (2) that even if she is not able to make this decision independently, the desired abortion would be in her best interests. The proceeding in which this showing is made must assure that a resolution of the issue, and any appeals that may follow, will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained.

Bellotti II, 443 U.S. at 622.

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23. The district court held that the requirement of "informed" parental consent would necessitate in-person parental consent. We need not decide whether that is correct, for any burden caused by one-parent, in-person consent is surely no more than that caused by two-parent consent. *cf. Hodgson*, 110 S. Ct. at 2970; and the Supreme Court has held that a judicial bypass option alleviates the undue burden caused by two-parent consent requirements.

The Pennsylvania Act's bypass procedure complies with each of the four requirements set forth in *Bellotti II*. Under § 3206, if a minor woman does not wish to or cannot obtain the consent of a parent, she may file a motion or petition with the court of common pleas in the district where she lives or in which the abortion is sought. A judge of the court of common pleas must hold a hearing, at which the woman has a right to court-appointed counsel. At the hearing, the judge must determine if the woman is mature and able to make her own decision and has in fact consented to the abortion. If so, the judge must allow the abortion. Furthermore, if the judge finds that the woman is not mature and able to make her own decision, the judge must decide if an abortion would nevertheless be in her best interests. 18 Pa. Cons. Stat. Ann. § 3206 (c)-(d) (1983 & Supp. 1991). This statutory language mirrors the *Bellotti II* requirements for the factors that must guide a judge in making this decision.

In accordance with *Bellotti II*, the statute requires that the proceedings be confidential. *Id.* § 3206(f). Initials must be used to identify the woman in all documents. The hearing before the common pleas judge must be closed, and the appeals procedure must also be confidential. The record of the proceedings must be sealed.

Section 3206 also meets the promptness requirement of *Bellotti II*. Section 3206 requires that the court hold the hearing and render a decision within three business days of the application by the woman. The woman has a right to appeal to the Superior Court if the court of common pleas does not grant her permission. The Superior Court decision must be rendered within five business days of the filing of an appeal. *Id.*

§ 3206 (f), (h). This entire procedure should last no longer than eight business days. In *Ohio*, the Supreme Court upheld Ohio's bypass procedure, which required the trial court to make its decision within five business days and required the court of appeals to decide within nine days after the filing of a notice of appeal. 110 S. Ct. at 2980. The Pennsylvania statute requires a quicker decision than did Ohio's, and the Supreme Court held that Ohio's procedure was sufficiently prompt. The Commonwealth's bypass procedure thus meets the *Bellotti II* requirements and alleviates the undue burden that would be caused by a parental consent statute with no judicial bypass. *Cf. Glick v. McKay*, 937 F.2d 434 (9th Cir. 1991) (striking down parental consent statute because bypass provision did not specify time in which judge had to render decision).

We further conclude that requiring parental consent in combination with a judicial bypass procedure passes rational basis review. It is not irrational for the state to require adult guidance for a minor woman, eleven or twelve years old in some cases, *see* 744 F. Supp. at 1343, in deciding whether to obtain an abortion. *See Hodgson*, 110 S. Ct. at 2950-51 (O'Connor, J., concurring); *Ohio*, 110 S. Ct. at 2983-84; *H.L. v. Matheson*, 450 U.S. 398, 411 (1981); *Bellotti II*, 443 U.S. at 634-37, 640-41; *Danforth*, 428 U.S. at 91 (Stewart, J., concurring).

D. *Spousal Notice*

Next, we address the issue in this case that presents the most difficult application of the undue burden standard. Section 3209 of the Act requires that, before a physician may perform an abortion on a married woman, the woman must

sign a statement that she has notified her husband of her intended abortion. The Commonwealth is to provide the forms for these statements, and each form must bear a notice that false statements are punishable by law. Besides the standard medical emergency exception, § 3209 contains four other important exceptions. A woman is not required to notify her husband if: (1) her husband is not the father; (2) her husband, after diligent effort, cannot be located; (3) the pregnancy is a result of spousal sexual assault which has been reported to a law enforcement agency; or (4) the woman has reason to believe that notifying her husband is likely to result in the infliction of bodily injury by her spouse or by another individual.[24] If the woman provides a false

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24. Section 3209 of the Act states:

> (a) SPOUSAL NOTICE REQUIRED.—In order to further the Commonwealth's interest in promoting the integrity of the marital relationship and to protect a spouse's interests in having children within marriage and in protecting the prenatal life of that spouse's child, no physician shall perform an abortion on a married woman, except as provided in subsections (b) and (c), unless he or she has received a signed statement, which need not be notarized, from the woman upon whom the abortion is to be performed, that she has notified her spouse that she is about to undergo an abortion. The statement shall bear a notice that any false statement made therein is punishable by law.
>
> (b) EXCEPTIONS.—The statement certifying that the notice required by subsection (a) has been given need not be furnished where the woman provides the physician a signed statement certifying at least one of the following:
>
> (1) Her spouse is not the father of the child.
>
> (2) Her spouse, after diligent effort, could not be located.

statement on the form, she may be liable for a misdemeanor of the third degree. Any physician who performs an abortion without complying with this section may be subject to civil penalties.

First, we must consider whether § 3209 imposes an undue burden on the woman's abortion decision. At this point, it is important to emphasize that we do not consider the countervailing interest of the husband; we consider *only* the burden imposed on the woman. After we conduct this threshold analysis, as we must, *then* we will address the Commonwealth's interest in furthering the husband's interest.

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(3) The pregnancy is a result of spousal sexual assault as described in section 3128 (relating to spousal sexual assault), which has been reported to a law enforcement agency having the requisite jurisdiction.

(4) The woman has reason to believe that the furnishing of notice to her spouse is likely to result in the infliction of bodily injury upon her by her spouse or by another individual.

Such statements need not be notarized, but shall bear a notice that any false statements made therein are punishable by law.

(c) MEDICAL EMERGENCY.—The requirements of subsection (a) shall not apply in the case of a medical emergency.

. . .

(e) PENALTY; CIVIL ACTION.— Any physician who violates the provisions of this section is guilty of "unprofessional conduct," and his or her license for the practice of medicine and surgery shall be subject to suspension or revocation . . . . In addition, any physician who knowingly violates the provisions of this section shall be civilly liable to the spouse who is the father of the aborted child for any damages caused thereby and for punitive damages in the amount of $5,000, and the court shall award a prevailing plaintiff a reasonable attorney fee as part of costs.

A spousal notice requirement does not cause a drastic or severe time delay, increase in costs, or decrease in the number of abortion providers. Nor does it give a state-sanctioned veto power over the woman's abortion decision to another person. But as Justice O'Connor noted in *Hodgson*, a provision requiring a woman to notify another person before obtaining an abortion can impose an undue burden in two other ways. First, the act of finding the person to whom notice must be given may constitute an undue burden. In *Hodgson*, so many parents in Minnesota were divorced that it would have been a great burden in many cases for the child to track down the other parent. This is not a problem with the Commonwealth's spousal notification requirement, however, since it allows a woman to certify that her husband, after diligent effort, could not be notified. Second, the giving of notice and the consequences thereof may constitute a severe limitation on the woman's abortion decision. The notified person, for example, may effectively prevent the abortion or may severely penalize the woman in other ways if she exercises her right to obtain an abortion. *Cf. Hodgson*, 110 S. Ct. at 2939. Such consequences were found to constitute undue burdens on a woman's right to an abortion in both *Bellotti II* and *Hodgson*.

In *Bellotti v. Baird* ("*Bellotti I*"), 428 U.S. 132, 145 (1976), the Court noted that one proffered interpretation of the Massachusetts statute requiring parental consent would allow minor women to obtain permission for abortion in a bypass proceeding, thus avoiding the "undue burden" caused by forced "consultation." Then, in *Bellotti II*, the Court held that the statute did not meet constitutional standards because, as

construed by the courts of Massachusetts, the bypass procedure was available only after the minor had notified, and unsuccessfully sought consent from, her parents. The Court concluded:

> We think that, construed in this manner, § 12S would impose an undue burden upon the exercise by minors of the right to seek an abortion. As the District Court recognized, "there are parents who would obstruct, and perhaps altogether prevent, the minor's right to go to court." *Baird III*, 450 F. Supp. at 1001. There is no reason to believe that this would be so in the majority of cases where consent is withheld. But many parents hold strong views on the subject of abortion, and young pregnant minors, especially those living at home, are particularly vulnerable to their parents' efforts to obstruct both an abortion and their access to court.

Bellotti II, 443 U.S. at 647.

In *Hodgson*, the Court rejected a two-parent notice requirement that did not provide a judicial bypass option. As we have noted, Justice O'Connor, the fifth vote necessary for the majority, found that a two-parent notification requirement was an "undue burden" on the abortion decision. 110 S. Ct. at 2950.[25] Justice Stevens, writing for

25. Judge Alito disagrees with our interpretation of Justice O'Connor's application of the undue burden standard in *Hodgson*. We agree with Judge Alito that Part I of Justice O'Connor's opinion in *Hodgson* is ambiguous; however, Part II clarifies her reasoning. As we noted above, Justice O'Connor in Part II of her opinion in *Hodgson* explained that the Court often had approved parental consent and notice provisions that contained a bypass option because a bypass option tailors a consent or notice statute "so as to avoid unduly burdening" the abortion right. *Hodgson*, 110 S. Ct. at 2950 (O'Connor, J., concurring). Justice O'Connor thus found constitutional the Minnesota statute that contained the

a majority of the Justices, including Justice O'Connor, described the burden imposed by the notice requirement in the following terms:

> The record reveals that in the thousands of dysfunctional families affected by this statute, the two-parent notice requirement proved positively harmful to the minor and her family. The testimony at trial established that this requirement, ostensibly designed for the benefit of the minor, resulted in major trauma to the child, and often to a parent as well. In some cases, the parents were divorced and the second parent did not have custody or otherwise participate in the child's upbringing. App. 244-245; *id.* at 466; *id.* at 115. In these circumstances, the privacy of the parent and child was violated, even when they suffered no other physical or psychological harm. In other instances, however, the second parent had either deserted or abused the child, *id.* at 462, 464, had died under tragic circumstances, *id.* at 120-121, or was not notified because of the considered judgment that notification would inflict unnecessary stress on a parent who was ill. *Id.* at 204, 465.
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> * * *
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> The most common reason for not notifying the second parent was that that parent was a child or spouse-batterer. App. at 204, and notification would have provoked further abuse.

bypass option. If a bypass procedure renders a parental notice provision constitutional because it alleviates the undue burden of the notice requirement, we think it follows that a parental notice requirement without the bypass option constitutes an undue burden.

Hodgson, 110 S. Ct. at 2945 & n.36.

The Supreme Court has thus been attuned to the real-world consequences of forced notification in the context of minor child/parent relationships and has found an undue burden to exist where there is a realistic likelihood either of parents preventing the abortion or of parents causing serious physical or psychological trauma for the pregnant child. In this case, we conclude that the real-world consequences of forced notification in the context of wife/husband relationships impose similar kinds of undue burdens on a woman's right to an abortion.

Most married women will discuss the abortion decision with their husbands. As Justice Stevens noted in *Hodgson*, a notification requirement is unnecessary and serves no state interest in those instances. 110 S. Ct. at 2945. The relevant burdens to be assessed are those imposed by § 3209 on women who would choose not to notify their husbands in the absence of state compulsion to do so.

The district court found that § 3209's notification requirement creates a substantial risk that women who would otherwise have an abortion will be prevented from having one. Abortion is a matter about which individuals have deeply held and strongly felt convictions, often rooted in moral or religious commitment. In those situations where a husband is sufficiently opposed to abortion or sufficiently desirous of having a child that the wife will not voluntarily share the fact of her pregnancy and her intention to abort with him, the clinics' experts testified that coerced notification will predictably result in an effort to prevent the abortion. That testimony showed that the husband's response will frequently take a variety of forms other than persuasive discourse.

Many husbands are capable of violence in circumstances of this kind and will use physical force and the threat thereof to keep the wife from access to the clinic. But physical force is not the only means at the disposal of a husband who seeks to prevent an abortion. In the numerous households where the husband alone holds the economic power, the wife is in as vulnerable a position as the pregnant minor discussed in *Bellotti II*. The husband can simply decline to pay for the abortion and/or threaten to withhold future economic support unless the woman decides to forego the abortion. Finally, the record reveals that the forms of effective psychological coercion available to a husband are potentially unlimited and include the ultimate threat of a dissolution of the marriage.

One form of psychological coercion warrants special note because of the potential toll it may take on the wife and its resulting effectiveness as a deterrent. We have often spoken about the value placed by our society on the right of each individual to privacy concerning personal health information. *See, e.g., United States v. Westinghouse Electric Corp.*, 638 F.2d 571, 577 (3d Cir. 1980); *see also Whalen v. Roe*, 429 U.S. 589, 599-600 (1977). The only thing we can think of more personal and intimate than the fact that one is carrying a child is the fact that one intends to seek an abortion. When the state forces spousal notification on a wife in a seriously troubled marriage, or even a wife in an untroubled marriage with a husband unalterably opposed to abortion, it compels disclosure of very intimate information with no assurance of confidentiality to someone highly motivated to make a public disclosure. As the district court found, the threat of exposure of

the abortion decision to family, friends, and the community at large is likely to be a very substantial deterrent to a woman's pursuing her decision to abort.

Prevention of a planned abortion is not the only foreseeable consequence of coerced notification, however. Even if the woman is not deterred from pursuing an abortion, the same arsenal of physical, economic, and psychological abuse is available to the notified husband to penalize the wife for exercising her constitutionally bestowed right. Nor is the effect of § 3209 limited to those situations in which the wife gives notice pursuant to the statute. Just as the principal power of Damocles' sword is in its hanging rather than its fall, the primary effect of § 3209 may well be on those women who desire an abortion but who choose to carry to term because of the feared consequences of giving notice to their husbands.

The Pennsylvania legislature has not been unmindful of the burdens imposed on pregnant wives by § 3209 and has attempted to ease or avoid a number of them by including exceptions. Section 3209, for example, speaks to the dilemma of a woman who "has reason to believe that the furnishing of notice to her spouse is likely to result in the infliction of bodily injury upon her by her spouse or by another individual." A woman with such a fear may avoid notification by certifying her fear to her physician on a form provided by the Commonwealth. While ameliorative, this exception does not save § 3209 from being unduly burdensome in the constitutional sense. The district court found, with appropriate record support, that battered spouses are psychologically incapacitated from making the assertion required by the statute even when there is ample objective

basis for the required fear. Many other women who have never before been the victims of "bodily injury" at the hands of their husband, may subjectively fear that notice may occasion "the first time," but conclude that they lack the requisite "reason to believe." Moreover, it is not clear to us that the "fear of bodily injury" exception was intended to aid those women whose access to an abortion is blocked by physical constraints or who reasonably fear physical abuse and the attendant suffering, but cannot conscientiously represent that injury to their bodies is likely to occur.

If physical violence were the only burden reasonably predictable from coerced spousal notification we might be inclined in this facial challenge to hold that the fear of bodily injury exception was sufficient to avoid an undue burden, at least until the effects of the Act in practice are known. But as we have previously stressed, physical violence is *not* the only burden reasonably predictable. The record reveals and the district court found that if § 3209 is allowed to go into effect, abortions can and will be prevented by economic and psychological duress and wives can and will be penalized by such duress for electing abortions.

One other of § 3209's exceptions warrants comment in our assessment of the burdens imposed by that section. The record demonstrates and the district court found that many women consent to sexual intercourse with their husbands solely to avoid greater physical or psychological abuse. Section 3209 provides that when a child is conceived in the course of coerced sex, notification need not be given, if, but only if, the wife reports her husband to law enforcement authorities having jurisdiction over the matter. While this limitation

on the exception is understandably imposed to discourage misrepresentations at the time an abortion is sought, its motivation does not ease the impact of the notification requirement on a woman who finds herself pregnant as a result of a sexual assault by her spouse. Given the devastating effect that a report to law enforcement authorities is likely to have on the marital relationship and the economic support provided the wife by the marriage, we believe it would be unrealistic to find that such a woman's right to choose an abortion is not severely burdened by § 3209. *Cf. Hodgson*, 110 S. Ct. at 2950 (O'Connor, J., concurring).

Because of the nature of the marriage relationship and the emotional character of human response to pregnancy and abortion, the number of different situations in which women may reasonably fear dire consequences from notifying their husbands is potentially limitless.[26] Because fear of those consequences is likely to dissuade many from seeking an abortion if such notification is required and because the consequences themselves are an undue burden, we hold that § 3209 constitutes an undue burden on a woman's abortion decision.

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26. The district court's list of situations in which spousal notification is likely to cause dire consequences for the women include, *inter alia*: women who reasonably fear retaliatory psychological abuse; women who reasonably fear retaliatory physical or psychological abuse of their children; women who are separated following a failed marriage relationship and for whom renewal of contact may produce severe emotional distress; women whose husbands have serious health problems and who reasonably fear that notification will be health threatening; and women whose marriages are severely troubled and who reasonably fear that notice will precipitate the demise of the marital relationship. 744 F. Supp. at 1386 n.42.

Accordingly, we must apply strict scrutiny to determine if § 3209 is narrowly tailored to serve a compelling state interest. Section 3209 expressly states that the spousal notice requirement is designed to further three state interests: promoting the integrity of the marital relationship, protecting a spouse's interests in having children within marriage, and protecting a spouse's interest in the prenatal life of that spouse's child.

We turn first to marital integrity. It is not entirely clear what the Commonwealth means when it speaks of the integrity of a marriage. If the interest is in honesty and full disclosure between married individuals, *Hodgson* indicates that this interest does not rise to the level of a legitimate state interest, much less a compelling one. In the course of striking down Minnesota's two-parent notice requirement without a judicial bypass, Justice Stevens there wrote for a majority of the court:

> The State does not rely primarily on the best interests of the minor in defending this statute. Rather, it argues that, in the ideal family, the minor should make her decision only after consultation with both parents who should naturally be concerned with the child's welfare and that the State has an interest in protecting the independent right of the parents "to determine and strive for what they believe to be best for their children." Minn.Br. 26. Neither of these reasons can justify the two-parent notification requirement. The second parent may well have an interest in the minor's abortion decision, making full communication among all members of a family desirable in some cases, but such communication may not be decreed by the State. The State has no more interest in

> requiring all family members to talk with one another than it has in requiring certain of them to live together. . . . [A] state interest in standardizing its children and adults, making the "private realm of family life" conform to some state-designed ideal, is not a legitimate state interest at all.

Hodgson, 110 S. Ct. at 2946.

If the state's alleged interest in the integrity of the marriage refers to the state's interest in keeping married individuals together in wedlock, we agree that this is a legitimate state interest. It is not an interest that the Supreme Court has recognized as a compelling one, however. Moreover, even if we were to assume that it does constitute a compelling state interest, we could not conclude that the Commonwealth has carried its burden of demonstrating that § 3209 is narrowly tailored to promote that interest. As we have noted, the only effect of § 3209 is to require notice in those instances in which the wife would not otherwise share with her husband the fact of the pregnancy and her intention to abort. In such situations, an across-the-board requirement of coerced disclosure is an altogether arbitrary approach to a difficult and complex problem of human relations. Nothing in this record suggests that replacing the wife's judgment regarding disclosure with such an arbitrary rule will save more marriages than it destroys.

The Commonwealth asserts that § 3209 furthers its interests in furthering the husband's interest both in having children within the marriage and in the fetus. To the extent that these interests are distinct, the abstract interest in having children within the marriage is not more substantial than

the interest in the fetus. Therefore, we will now turn to the most difficult issue: the state's interest in furthering the husband's interest in the individual fetus. In *Danforth*, in discussing a spousal consent requirement, the Court recognized the state's *legitimate* interest in the husband's interest in the fetus. Justice Blackmun for the Court stated that the Court was "not unaware" of the "deep and proper concern and interest" that a husband has in his wife's pregnancy and in the growth and development of the fetus she is carrying. *Danforth*, 428 U.S. at 69. Nevertheless, the Court struck down the spousal consent requirement in *Danforth*, finding that the state's interest in supporting the husband's interest in the fetus was insufficient to override the wife's right to an abortion:

> Notwithstanding these factors, we cannot hold that the State has the constitutional authority to give the spouse unilaterally the ability to prohibit the wife from terminating her pregnancy, when the State itself lacks that right. *See Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).
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> As the Court recognized in *Eisenstadt v. Baird*, "the marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional makeup. If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." 405 U.S., at 453 (emphasis in original).

Danforth, 428 U.S. at 70 & n.11. *Danforth* can be

read to stand for the proposition that the state's interest in protecting a husband's interest in a previable fetus within his marriage is not a compelling one. It must be read at least to hold that that interest must yield to the wife's right to have an abortion. Thus, the state cannot vindicate the husband's interest in a fetus, and § 3209 was enacted with that realization.

Section 3209, despite its preamble, does not protect the husband's interest in the fetus; under *Danforth*, as we have noted, a state statute cannot constitutionally protect that interest. What § 3209 seeks to preserve for the husband is something considerably more modest: the possibility of participating in a decision his wife is constitutionally privileged to make on her own for her own reasons. While promoting the possibility of spousal participation is undoubtedly a legitimate state interest, we conclude in light of *Danforth* that it is not the kind of compelling state interest that can justify the very substantial burdens imposed by § 3209 on the wife's right to choose an abortion.

In sum, we hold that § 3209 is unconstitutional because it imposes an undue burden on a woman's abortion decision and does not serve a compelling state interest.[27]

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27. Our conclusion that § 3209 is unconstitutional does not prevent the Commonwealth from putting into effect the rest of the Act's provisions. The Act contains a broad severability provision. "The provisions of this act are severable. If any word, phrase or provision of this act or its application to any person or circumstance is held invalid, the invalidity shall not affect any other word, phrase or provision or application of this act which can be given effect without the invalid word, phrase, provision or application." Act of November 17, 1989, 1989 Pa. Laws 592, No. 64, § 6. In addition, Pennsylvania has a general severability statute. 1 Pa. Cons. Stat. Ann. § 1925 (Supp. 1991). Severability is a question of state law. *Davis v. Michigan Dept. of Treasury*, 489 U.S. 803, 818 (1989). Because the remainder of the Act may be given effect without § 3209, we conclude that § 3209 may be severed from the Act in accordance with Pennsylvania law.

E. *Confidential Medical Reports*

An abortion provider must file a report with the Department of Health for every abortion performed at its facility. 18 Pa. Cons. Stat. Ann. § 3214(a) (1983 & Supp. 1991). Each report must include a variety of information about the abortion.[28] Because these reports are not open for public inspection and are subject to various safeguards against disclosure, *id.* § 3214(b), the district court concluded – and the clinics do not challenge the conclusion – that the Commonwealth had adequately assured the confidentiality of these reports.

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28. The relevant text of § 3214 provides:

> (a) GENERAL RULE.– For the purpose of promotion of maternal health and life by adding to the sum of medical and public health knowledge through the compilation of relevant data, and to promote the Commonwealth's interest in protection of the unborn child, a report of each abortion performed shall be made to the department on forms prescribed by it. The report forms shall not identify the individual patient by name and shall include the following information:
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> (1) Identification of the physician who performed the abortion, the concurring physician as required by section 3211(c)(2) (relating to abortion on unborn child of 24 or more weeks gestational age), the second physician as required by section 3211(c)(5) and the facility where the abortion was performed and of the referring physician, agency or service, if any.
>
> (2) The county and state in which the woman resides.

In *Danforth*, the Court held that recordkeeping and reporting requirements are permissible so long

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(3). The woman's age.

(4) The number of prior pregnancies and prior abortions of the woman.

(5) The gestational age of the unborn child at the time of the abortion.

(6) The type of procedure performed or prescribed and the date of the abortion.

(7) Pre-existing medical conditions of the woman which would complicate pregnancy, if any, and, if known, any medical complication which resulted from the abortion itself.

(8) The basis for the medical judgment of the physician who performed the abortion that the abortion was necessary to prevent either the death of the pregnant woman or the substantial and irreversible impairment of a major bodily function of the woman, where an abortion has been performed pursuant to section 3211(b)(1).

(9) The weight of the aborted child for any abortion performed pursuant to section 3211(b)(1).

(10) Basis for any medical judgment that a medical emergency existed which excused the physician from compliance with any provision of this chapter.

(11) The information required to be reported under section 3210(a) (relating to determination of gestational age).

(12) Whether the abortion was performed upon a married woman and, if so, whether notice to her spouse was given. If no notice to her spouse was given, the report shall also indicate the reason for failure to provide notice.

(b) COMPLETION OF REPORT.– The report shall be completed by the hospital or other licensed facility, signed by the physician who performed the abortion and transmitted to the department within 15 days after each reporting month.

as they are not used to accomplish "through the sheer burden of recordkeeping detail, what [the Court has] held to be an otherwise unconstitutional restriction," and so long as the reports are confidential. *Danforth*, 428 U.S. at 81. Furthermore, the reports must be rationally related to a legitimate state interest. *Id.*

The district court concluded that the Commonwealth could not constitutionally require

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. . .

(i) PENALTIES.–

(1) Any person required under this section to file a report, keep any records or supply any information, who willfully fails to file such report, keep such records or supply such information at the time or times required by law or regulation is guilty of "unprofessional conduct" and his license for the practice of medicine and surgery shall be subject to suspension or revocation in accordance with procedures provided under the act of October 5, 1978 (P.L. 1109, No. 261), known as the Osteopathic Medical Practice Act, the act of December 20, 1985 (P.L. 457, No. 112), known as the Medical Practice Act of 1985, or their successor acts.

(2) Any person who willfully delivers or discloses to the department any report, record or information known by him to be false commits a misdemeanor of the first degree.

(3) In addition to the above penalties, any person, organization or facility who willfully violates any of the provisions of this section requiring reporting shall upon conviction thereof:

(i) For the first time, have its license suspended for a period of six months.

(ii) For the second time, have its license suspended for a period of one year.

(iii) For the third time, have its license revoked.

18 Pa. Cons. Stat. Ann. § 3214(a), (i) (1983 & Supp. 1991).

of a doctor or clinic four of the many items of information listed in the statute: (1) the basis for the physician's determination of gestational age; (2) in a third trimester abortion, the basis for the physician's decision that a third trimester abortion was necessary for the life or health of the mother; (3) in a medical emergency case, the basis for the physician's decision that a medical emergency suspended the statute's requirements; and (4) the identity of the referring physician.[29] 744 F. Supp. at 1391-95.

First, we address the three reporting requirements relating to the physician's medical judgments for particular types of abortions. The abortion provider must file one report for every abortion. The report will not cause by the "sheer burden of recordkeeping detail" a drastic increase in delay or cost, or a drastic decrease in availability. The district court's only relevant finding on this point was that compliance with this section had cost $12,000 per year for a clinic that performed 7,000 abortions per year. 744 F. Supp. at 1337, 1372. An added cost of at most a few dollars per abortion that the clinics may pass on to patients is not the kind of "drastic" increase necessary to constitute an undue burden. In addition, the reports are concededly confidential, and the reporting requirement does not constitute an undue burden on that basis. The reports are also rationally related to preservation of maternal health; they will enable the Commonwealth to

29. The Court in *Thornburgh* struck down similar reporting requirements because they were not confidential, 476 U.S. at 765-68; in that case, the report could unduly burden the abortion right by making public both information about the women who obtain abortions and information about the doctors who perform them.

discover how often and under what circumstances women obtain medically necessary abortions. Finally, the reports will confirm that clinics and physicians are complying with the Act's requirements.

The district court concluded that such a report would have a "chilling effect" on the exercise of the physician's judgment. We fail to perceive a chilling effect, however, other than on a physician who is not complying with the other provisions of the Act for medical emergencies, determination of gestational age, and third trimester abortions. Because those provisions themselves are constitutional, it seems unremarkable and not unduly burdensome that the Commonwealth requires this information in a report concerning an abortion.

With respect to the requirement of § 3214(a)(1) that the report concerning an abortion include the name of the performing and referring physicians, the district court concluded that the record was devoid of any evidence that a *performing* physician would be deterred from performing abortions by the requirement that the report include his or her name. 744 F. Supp. at 1391-92. Nevertheless, the district court concluded that some physicians might stop *referring* women for abortions if their names were included in the confidential report. *Id.* at 1392. The testimony at trial established that referring physicians zealously protect their anonymity, and we would face a different and more difficult case if there were a significant risk that such information would be disclosed. But given the district court's conclusions about the safeguards that will ensure confidentiality, we decline to conclude that referring physicians will be deterred in sufffficient number that the availability of an

abortion will be drastically reduced. Accordingly, we conclude that the requirement of disclosure of the identity of the names of the referred and performing physicians need only satisfy rational basis review.

As to rational basis, the district court found that the performing physician's name was properly included because he or she could answer questions that might arise about information contained in the reports. However, the district court felt that no similar reason existed for the referring physician's name. *Id.* This conclusion ignores the fact that the referring physician can perform some of the Act's requirements; the Act allows referring physicians both to obtain the woman's informed consent and to determine gestational age. We thus conclude that this requirement is rationally related to a legitimate state interest.

We hold that the confidential reporting requirements of § 3214(a) are constitutional.

F. *Publicly Available Reports*

Abortion facilities must file with the Department of Health a report supplying the name and address of the facility and the name and address of affiliated organizations, such as parent or subsidiary corporations. 18 Pa. Cons. Stat. Ann. § 3207(b) (Supp. 1991).[30] Every abortion facility

30. Section 3207(b) provides:

Within 30 days after the effective date of this chapter, every facility at which abortions are performed shall file, and update immediately upon any change, a report with the department, containing the following information:

(1) Name and address of the facility.

must also file a report showing the total number of abortions performed, broken down by trimester, at the facility during the preceding quarter year. 18 Pa. Cons. Stat. Ann. § 3214(f) (1991 Supp.).[31]

(2) Name and address of any parent, subsidiary or affiliated organizations, corporations or associations.

(3) Name and address of any parent, subsidiary or affiliated organizations, corporations or associations having contemporaneous commonality of ownership, beneficial interest, directorship or officership with any other facility.

The information contained in those reports which are filed pursuant to this subsection by facilities which receive State appropriated funds during the 12-calendar-month period immediately preceding a request to inspect or copy such reports shall be deemed public information. Reports filed by facilities which do not receive State appropriated funds shall only be available to law enforcement officials, the State Board of Medicine and the State Board of Osteopathic Medicine for use in the performance of their official duties. Any facility failing to comply with the provisions of this subsection shall be assessed by the department a fine of $500 for each day it is in violation hereof.

31. Section 3214(f) provides:

Every facility in which an abortion is performed within this Commonwealth during any quarter year shall file with the department a report showing the total number of abortions performed within the hospital or other facility during that quarter year. This report shall also show the total abortions performed in each trimester of pregnancy. Any report shall be available for public inspection and copying only if the facility receives State-appropriated funds within the 12-calendar-month period immediately preceding the filing of the report. These reports shall be submitted on a form prescribed by the department which will enable a facility to indicate whether or not it is receiving State-appropriated funds. If the facility indicates on the form that it is not receiving State-appropriated funds, the department shall regard its report as confidential unless it receives other evidence which causes it to conclude that the facility receives State-appropriated funds.

If a facility has received public funds during the preceding year, the reports must be made available to the public.

The clinics do not attack these reporting requirements; they challenge only the mandate that reports of clinics receiving public funds be available to the public. More specifically, the argument presented by the clinics—and accepted by the district court—is that public disclosure of these reports will cause protests in front of clinics to proliferate and intensify, and that this will eventually reduce the number of abortion providers and the availability of abortions. Like the district court, we recognize that substantial public protest, directed toward both the clinics and the women entering them, occurs in front of abortion clinics. *See, e.g., Northeast Women's Center v. McMonagle*, ___ F.2d ___ (3d Cir. 1991). In its opinion, the district court detailed much of this activity and then concluded that the clinics had reasonable fears of increased protest from the public disclosure of these reports. The district court also concluded that some clinics might refuse the funds they receive for medically necessary abortions in order to avoid having their reports made available to the public. 744 F. Supp. at 1390-91.

We have considered this issue before in addressing nearly the same reporting requirements. *American College of Obstetricians v. Thornburgh*, 737 F.2d 283, 297-98 (3d Cir. 1984) ("*ACOG*"), *aff'd on other grounds*, 476 U.S. 747 (1986). Unless the clinics show a clear nexus between the disclosure requirement and increased private harassment, any attempt to argue that this requirement constitutes an undue burden fails.

ACOG, 737 F.2d at 297-98. Here, the clinics have not shown that the public disclosure requirement will so enlarge the number or escalate the severity of protests that they will become an absolute obstacle or severe limitation on a woman's abortion right. The clinics are publicly advertised and listed in the phone book, and many, if not all, encounter protests and demonstrations without this requirement. On the record as we review it—at a time before this provision has been implemented—we cannot conclude that the public disclosure requirement will result in an absolute obstacle or severe limitation on a woman's abortion decision. We thus conclude, as we did in the previous incarnation of this challenge, that §§ 3207(b) and 3214(f) do not constitute an undue burden because the clinics have not "demonstrated a nexus between the disclosure of such information and the chilling of constitutional rights." *Id.* at 297.

The next question is whether this provision is rationally related to a legitimate state interest. Records relating to public expenditures and disbursements are generally available to the public under Pennsylvania law. 65 Pa. Cons. Stat. Ann. §§ 66.1, 66.2 (1959 & Supp. 1991). When a state provides money to a private commercial enterprise, there is a legitimate public interest in informing taxpayers who the funds are benefiting and what services the funds are supporting. Thus, this requirement does not lack a rational basis.

The clinics also argue that the public disclosure requirement is an unconstitutional condition on the receipt of public funds. Under the doctrine of unconstitutional conditions, "government may not grant a benefit on the condition that the beneficiary surrender a constitutional right, even

if the government may withhold that benefit altogether." Sullivan, *Unconstitutional Conditions*, 102 Harv. L. Rev. 1415, 1415 (1989). There are two major elements of a successful unconstitutional conditions challenge.

The first is that "the constitutional interest at issue . . . rise to the level of a recognized right—indeed a *preferred* right normally recognized by strict judicial review." *Id.* at 1427. In this case, the constitutional right to abortion is implicated by these requirements; however, as we concluded above, this right is not unduly burdened by these disclosure requirements and thus strict scrutiny is not triggered. Therefore, it is not an unconstitutional conditions problem in the way that it would be if the Commonwealth prohibited a recipient of public funds from performing abortions at all. *Cf. Babbitt v. Planned Parenthood*, 479 U.S. 925 (1986), *aff'g* 718 F.2d 938 (9th Cir. 1983).[32]

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32. The Supreme Court's abortion funding cases exemplify the second major element of an unconstitutional conditions case: the state may fund activities as it pleases, may refuse to fund other activities, and may prevent recipients of government funds from using those funds in ways the government does not permit; however, the government may not restrict a recipient of government funds from constitutionally-protected activities it chooses to perform with its own or private funds. *See Rust v. Sullivan*, 111 S. Ct. 1759 (1991).

The Supreme Court has used these principles in deciding a number of abortion funding cases. In *Maher v. Roe*, 432 U.S. 464 (1977), the Court upheld a state regulation under which Medicaid recipients received payment for medical services related to childbirth, but not for those related to nontherapeutic abortions. Similarly, in *Poelker v. Doe*, 432 U.S. 519 (1977), the Court upheld a city's policy of providing publicly financed hospital services for childbirth without

Having concluded that this requirement does not unduly burden the abortion right, rationally relates to a legitimate state interest, and does not present an unconstitutional condition on the receipt of public funds, we uphold §§ 3207(b) and 3214(f).

IV.

We conclude that the undue burden standard adopted by Justice O'Connor was the narrowest grounds in the majority in *Webster* and *Hodgson* and is at present the law of the land. Applying the undue burden standard, we conclude that § 3209, the spousal notice provision, constitutes an undue burden. Since the state does not have a compelling interest in ensuring spousal notice, we hold § 3209 unconstitutional. However, none of the other provisions at issue here constitutes an undue burden, and each is rationally related to a legitimate state purpose. Thus, we uphold them against the clinics' challenge. We will affirm in part and reverse in part the judgment of the district court.

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providing corresponding services for nontherapeutic abortions. In *Harris v. McRae*, 448 U.S. 297 (1980), the Court upheld the federal government's refusal to fund medically necessary abortions though it funded other medically necessary services. In *Webster*, the Court upheld a state's ban on the use of public employees and facilities for the performance or assistance of nontherapeutic abortions. In *Rust*, the Court upheld the federal government's refusal to fund programs that refer women for abortions.

In the one abortion funding case where the Court has struck down a government restriction on abortion funding, a state had attempted to prohibit any recipient of any state funds from performing abortions, even if that recipient wished to provide abortion services with private funds. *Babbitt*, 479 U.S. at 925. The problem in *Babbitt* was that the government had attempted to prohibit a recipient of government funds from using its own funds to exercise its constitutional right; that is an unconstitutional condition, but not one imposed by the legislation before us.

ALITO, *Circuit Judge*, concurring in part and dissenting in part.

I concur in the court's judgment except insofar as it holds that 18 Pa. Cons. Stat. Ann. § 3209 (Supp. 1991) (spousal notice) is unconstitutional. I also join all of the court's opinion except for the portions concerning Section 3209 and those interpreting Justice O'Connor's opinion in *Hodgson v. Minnesota*, 110 S.Ct. 2926, 2949-51 (1990), to mean that the two-parent notification requirement without judicial bypass imposed an "undue burden" and was thus required to satisfy strict scrutiny.

I.

As the court suggests, the crux of this case concerns the identification of the constitutional standard that the lower courts must now apply in cases involving laws regulating abortion. For the reasons carefully explained in the court's opinion, I agree that *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), and *Hodgson* changed the law that we are bound to apply and that the test set out in Justice O'Connor's opinions now represents the governing legal standard.

My disagreement with the majority regarding a single provision of the Pennsylvania Abortion Control Act, 18 Pa. Cons. Stat. Ann. § 3201 *et seq.* (1983 & Supp. 1991), results from disagreement about the portion of Justice O'Connor's two-part test that must be applied to this provision. Under that test, as the majority explains, a law that imposes an "undue burden" must serve a "compelling" state interest. By contrast, a law that does not impose an "undue burden" must simply be "rationally" or "reasonably" related to a "legitimate" state interest.

The majority holds that Section 3209 constitutes an undue burden. The majority therefore applies the first prong of the two-part test and strikes down Section 3209 on the ground that it does not serve a "compelling" interest. I do not believe that Section 3209 has been shown to impose an undue burden as that term is used in the relevant Supreme Court opinions; I therefore apply the second prong of the two-part test; and I conclude that Section 3209 is constitutional because it is "rationally related" to a "legitimate" state interest.

Although the majority and I apply different prongs of this two-part test, I see no indication that we disagree concerning the conclusion produced when either prong is applied to Section 3209. If the majority is correct that Section 3209 must satisfy heightened scrutiny, I agree that its constitutionality is doubtful. Similarly, I do not interpret the majority opinion to mean that Section 3209 cannot satisfy the rational relationship test. Indeed, the majority acknowledges that Section 3209 serves a "legitimate" interest. See majority typescript at 74, 77. Thus, my major disagreement with the majority concerns the question whether Section 3209 imposes an "undue burden," and I will therefore turn to that question.

II.

A. Justice O'Connor has explained the meaning of the term "undue burden" in several abortion opinions. In *Akron v. Akron Center for Reproductive Health*, 462 U.S. at 464 (O'Connor, J., dissenting), she wrote that "an 'undue burden' has been found for the most part in situations involving absolute obstacles or severe limitations on the abortion decision." She noted that laws held unconstitutional in prior cases involved statutes

that "criminalized *all* abortions except those necessary to save the life of the mother," inhibited "'the vast majority of abortions after the first 12 weeks,'" or gave the parents of a pregnant minor an absolute veto power over the abortion decision. *Id.* (emphasis in original; citations omitted). She suggested that an "undue burden" would not be created by "a state regulation [that] may 'inhibit' abortions to some degree." *Id.* She also suggested that there is no undue burden unless a measure has the effect of "*substantially* limiting access." *Id.* at 463, quoting *Carey v. Population Services International*, 431 U.S. 678, 688 (1977) (emphasis added in Justice O'Connor's opinion).

Justice O'Connor reiterated the same analysis in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). She wrote (*Id.* at 828 (O'Connor, J., dissenting), quoting *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting)):

> An undue burden would generally be found "in situations involving absolute obstacles or severe limitations on the abortion decision," not wherever a state regulation "may 'inhibit' abortions to some degree."

She also criticized the majority for taking an approach under which "the mere possibility that *some women* will be less likely to choose to have an abortion by virtue of the presence of a particular state regulation suffices to invalidate it." *Id.* at 829 (emphasis added).

Justice O'Connor's application of the undue burden test in several cases further illustrates the meaning of this test. In *Hodgson*, 110 S.Ct. at 2950-51, Justice O'Connor found that no undue burden was imposed by a law requiring notice to both parents or judicial authorization before a

minor could obtain an abortion. Justice O'Connor reached this conclusion despite statistics adduced by Justice Marshall to show that mandatory parental notice may inhibit a significant percentage of minors from obtaining abortions (*Id.* at 2953-54 (Marshall, J., dissenting) and despite the district court's finding, noted in Justice Marshall's dissent, that the judicial bypass option "so daunted" some minors that they felt compelled to carry to term (*Id.* at 2959, *quoting* 648 F.Supp. at 763).

Justice O'Connor has also suggested on more than one occasion that no undue burden was created by the statute upheld in *H. L. v. Matheson*, 450 U.S. 398 (1981), which required parental notice prior to any abortion on an unemancipated minor. Instead, she has stated that this statute merely inhibited abortions to "some degree." *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting); *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting). In dissent in *Matheson*, Justice Marshall argued that the statute would result in substantial interference with abortions sought by minors. He wrote (450 U.S. at 398) (Marshall, J., dissenting) that "the minor may confront physical or emotional abuse, withdrawal of financial support or actual obstruction of the abortion decision." These harms are almost identical to those that the majority in this case attributes to Section 3209. See majority typescript at 66-68. *See also Planned Parenthood Association v. Ashcroft*, 462 U.S. 476, 505 (1983) (O'Connor concurring and dissenting) (statute requiring parental consent or judicial authorization "imposes no undue burden").

Finally, Justice O'Connor has concluded that regulations that simply increase the cost of

abortions, including regulations that may double the cost, do not create an "undue burden." *See Akron*, 462 U.S. at 434-35 (maj. op.); 466-67 (O'Connor, J., dissenting). Justice O'Connor reached this conclusion even though it seems clear that such increased costs may well deter some women.

Taken together, Justice O'Connor's opinions reveal that an undue burden does not exist unless a law (a) prohibits abortion or gives another person the authority to veto an abortion or (b) has the practical effect of imposing "severe limitations," rather than simply inhibiting abortions "'to some degree'" or inhibiting "some women." *Thornburgh*, 476 U.S. at 828, 829 (O'Connor, J., dissenting), *quoting Akron*, 462 U.S. at 464 (O'Connor, J., dissenting). Furthermore, Justice O'Connor's opinions disclose that the practical effect of a law will not amount to an undue burden unless the effect is greater than the burden imposed on minors seeking abortions in *Hodgson* or *Matheson* or the burden created by the regulations in *Akron* that appreciably increased costs. Since the laws at issue in those cases had inhibiting effects that almost certainly were substantial enough to dissuade some women from obtaining abortions, it appears clear that an undue burden may not be established simply by showing that a law will have a heavy impact on a few women but that instead a broader inhibiting effect must be shown.

In this case, the plaintiffs, who made a facial attack[1] on Section 3209, did not prove that this

1. Because the plaintiffs made a facial attack on Section 3209, they could not rely on a "worst-case analysis" (*Ohio v. Akron Center for Reproductive Health*, 110 S. Ct. 2972, 2981 (1990)) or on proof showing only that the provision would impose an undue burden "under some conceivable set of

provision would impose an undue burden. Section 3209 does not create an "absolute obstacle" or give a husband "veto power." Rather, this provision merely requires a married woman desiring an abortion to certify that she has notified her husband or to claim one of the statutory exceptions.

The plaintiffs also failed to carry their burden[2] of proving that Section 3209 if enforced would have the kind of broad practical impact needed to establish an "undue burden" under the opinions discussed above. Clearly the plaintiffs did not substantiate the impact of Section 3209 with the degree of analytical rigor that should be demanded before striking down a state statute. Cf. *Akron*, 462 U.S. at 463 (O'Connor, J., dissenting) (citation omitted) (courts should exercise "'deliberate restraint'" before finding an undue burden "'in view of the respect that properly should be accorded legislative judgments'"); *id.* at 465.

circumstances" (*United States v. Salerno*, 481 U.S. 739, 745 (1987)). Thus, proof that the provision would adversely affect an unknown number of women with a particular combination of characteristics could not suffice.

2. In *Thornburgh*, Justice O'Connor made clear that a party challenging the constitutionality of a statute must bear the burden of proving that the law imposes an undue burden. After arguing strenuously that the case should be sent back to the district court for "additional factual development" (476 U.S. at 827 (O'Connor, J., dissenting), Justice O'Connor repeatedly stated that the appellees, who were challenging the statute, had the burden of proving that individual statutory provisions would impose an undue burden. She discussed whether "appellees could succeed in making the threshold showing of undue burden" (*id.* at 831), whether "appellees [could] establish that the abortion decision [would be] unduly burdened" (*id.*), and whether the appellees "could succeed in establishing an undue burden" (*id.* at 832).

At the outset, it is apparent that two factors imposed a low ceiling on any showing that the plaintiffs could have made. First, as the district court found, the "vast majority" of married women voluntarily inform their husbands before seeking an abortion. *Planned Parenthood v. Casey*, 744 F.Supp. 1232, 1360 (E.D. Pa. 1990). Indeed, in the trial testimony on which the district court relied, the plaintiffs' witness stated that in her experience 95% of married women notify their husbands. App. at 701. Second, the overwhelming majority of abortions are sought by unmarried women.[3] Thus, it is immediately apparent that Section 3209 cannot affect more than about 5% of married women seeking abortions or an even smaller percentage of all women desiring abortions.

The plaintiffs failed to show even roughly how many of the women in this small group would actually be adversely affected by Section 3209. As previously noted, Section 3209 contains four significant exceptions. These exceptions apply if a woman certifies that she has not notified her husband because she believes[4] that (1) he is not the father of the child, (2) he cannot be found after diligent effort, (3) the pregnancy is the result of a

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3. Since 1973, abortions on unmarried women have consistently exceeded 70% of the national total and at times have surpassed 80%. *United States Department of Commerce, Statistical Abstract of the United States 1990* at 71.

4. The form prepared by the Pennsylvania Department of Health for use in implementing Section 3209 requires a woman to certify that she has not notified her husband "for the following reason(s). . . ." (744 F.Supp. at 1359). Moreover, a false statement is punishable (as a third degree misdemeanor) only if the woman did not "believe [the statement] to be true" (18 Pa. Cons. Stat. Ann. § 4904(b) (1983)).

spousal sexual assault that has been reported to the authorities, or (4) she has reason to believe that notification is likely to result in the infliction of bodily injury upon her. If Section 3209 were allowed to take effect, it seems safe to assume that *some* percentage of the married women seeking abortions without notifying their husbands would qualify for and invoke these exceptions. The record, however, is devoid of evidence showing how many women could or could not invoke an exception.

Of the potentially affected women who could not invoke an exception, it seems safe to assume that *some* percentage, despite an initial inclination not to tell their husbands, would notify their husbands without suffering substantial ill effects. Again, however, the record lacks evidence showing how many women would or would not fall into this category. Thus, the plaintiffs did not even roughly substantiate how many women might be inhibited from obtaining an abortion or otherwise harmed by Section 3209.[5] At best, the record shows that

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5. In considering whether Section 3209 would impose an undue burden, I do *not* take into account a fact that seems glaringly apparent, i.e., that Section 3209 would be difficult to enforce and easy to evade. Section 3209 does not require a woman to provide any proof of notification other than her own unnotarized statement. Thus, if a woman claimed that she had orally notified her husband in private (the mode and place of notification to be expected in most cases), it would be exceedingly difficult in most cases for the Commonwealth to prove beyond a reasonable doubt that she had not done so.

Proving that a woman violated the law due to a false statement concerning one of the exceptions would also be hard. As noted (*see* footnote 4, *supra*), the Commonwealth would have to prove that the woman did not "believe [the

Section 3209 would inhibit abortions "'to some degree'" or that "some women [would] be less likely to choose to have an abortion by virtue of the presence" of Section 3209. *Thornburgh*, 476 U.S. at 828 (O'Connor, J., dissenting), quoting *Akron*, 462 U.S. at 464 (O'Connor, J., dissenting).[6] And

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statement] to be true" (18 Pa. Cons. Stat. Ann. § 4904(b) (1983)). Consequently, if a woman certified that she did not notify her husband because he was not the father, the Commonwealth would have to prove that she subjectively believed that the husband was the father. Or, if a woman certified that she did not notify her husband because she had reason to believe that this would lead to the infliction of bodily injury upon her, the Commonwealth would have to prove that the woman subjectively believed that she would not be harmed. It seems likely, therefore, that Section 3209, if allowed to take effect, would be widely evaded and infrequently enforced and would consequently be less likely to produce either the good or bad effects that the opposing parties claim.

6. The plaintiffs' proof may be separated into five categories. First, they offered testimony that a spousal notification requirement would sometimes delay an abortion or necessitate an extra trip to the abortion provider (*see* 744 F.Supp. at 1360). But as the majority properly concludes in rejecting identical objections to the 24-hour waiting period required by Section 3205(a) (see majority typescript at 52-55), these potential effects do not amount to an undue burden. *See Akron*, 462 U.S. at 472-74 (O'Connor, J., dissenting).

Second, the plaintiffs offered testimony that the exceptions in Section 3209 would not cover a case in which a woman did not want to notify her husband for fear that he would retaliate in some way other than the infliction of bodily injury upon her, such as by subjecting her to psychological abuse or abusing their children (*see* 744 F.Supp. at 1360-62). The plaintiffs, however, do not appear to have offered any evidence showing how many (or indeed that *any* actual women) would be affected by this asserted imperfection in the statute.

even with respect to these women, the plaintiffs did not show that the impact of Section 3209 would be any greater or any different from the impact of the notice requirement upheld in *Matheson*. Consequently, the plaintiffs failed to prove that Section 3209 would impose an undue burden.

Third, the plaintiffs introduced general evidence about the problem of spouse abuse (*see* 744 F.Supp. at 1361). They offered widely varying statistics concerning the dimensions of the problem, as well as evidence that battering occurs in all socioeconomic groups and is sometimes fatal. This proof, while documenting the existence of a broad national problem, provides no basis for any estimate of what is relevant here – the impact of Section 3209.

Fourth, the plaintiffs offered evidence that "mere notification of pregnancy is frequently a flashpoint for battering" (*see* 744 F.Supp. at 1361). This proof indicates *when* violence is likely to occur in an abusive marriage but provides no basis for determining how many women would be adversely affected by Section 3209.

Finally, the plaintiffs offered the opinion of one of their witnesses that most battered women would be psychologically incapable of taking advantage of Section 3209's fourth exception, i.e., the exception for cases in which the woman has reason to fear that notification will lead to the infliction of bodily harm upon her (*see* 744 F.Supp. at 1363). However, the plaintiffs failed to show how many of the women potentially affected by Section 3209 (married women seeking abortions without notifying their husbands) are victims of battering. Thus, the opinion offered by their expert, even if taken at face value, merely describes the likely behavior of most of the women in a group of unknown size. Clearly, then, this evidence does not show how many women would be inhibited or otherwise harmed by Section 3209. I cannot believe that a state statute may be held facially unconstitutional simply because one expert testifies that in her opinion the provision would harm a completely unknown number of women.

Needless to say, the plight of any women, no matter how few, who may suffer physical abuse or other harm as a result of this provision is a matter of grave concern. It is apparent that the Pennsylvania legislature considered this problem and attempted to prevent Section 3209 from causing adverse effects by adopting the four exceptions noted above. Whether the legislature's approach represents sound public policy is not a question for us to decide. Our task here is simply to decide whether Section 3209 meets constitutional standards. The first step in this analysis is to determine whether Section 3209 has been shown to create an undue burden under Supreme Court precedent, and for the reasons just explained it seems clear that an undue burden has not been established.

B. This conclusion is not undermined (and may indeed be supported) by the portion of Justice O'Connor's opinion in *Hodgson* regarding the constitutionality of the two-parent notice requirement without judicial bypass. The majority in this case interprets Justice O'Connor's opinion to mean that this requirement imposed an undue burden and did not serve a "compelling" interest. Majority typescript 26, 28. I interpret Justice O'Connor's opinion differently. I do not read her opinion to mean that the two-parent notice requirement without judicial bypass constituted an undue burden. Rather, I interpret her opinion to mean that this requirement was unconstitutional because it was not reasonably related to a legitimate state interest. Thus, I do not believe that her opinion (or the Court's holding) supports the majority's conclusion in the present case that the spousal notification requirement in Section 3209 imposes an undue burden.

In *Hodgson*, Justice Stevens wrote the lead opinion discussing the unconstitutionality of the two-parent notification requirement without judicial bypass, and Justice O'Connor joined most of Justice Stevens' opinion (*see* 110 S. Ct. at 2949 (O'Connor, J., concurring). Thus, in interpreting Justice O'Connor's position, it is helpful to begin with the relevant portions of Justice Stevens' opinion.

Two portions of Justice Stevens' opinion, Parts III and VII, are most important for present purposes. In Part III, Justice Stevens discussed the applicable constitutional standard. Nowhere in this portion of his opinion (or indeed in any portion of his opinion) did Justice Stevens make reference to "strict," "exacting," or "heightened" scrutiny or any of the terminology associated with that level of review. Instead, he concluded that the statute failed to satisfy even the least demanding standard of review. He wrote (110 S. Ct. at 2937): "Under any analysis, the . . . statute cannot be sustained if the obstacles it imposes are not reasonably related to legitimate state interests."

In Part VII of his opinion, Justice Stevens explained (*id.* at 2945) why the two-parent notice requirement did not "reasonably further any legitimate state interest." Thus it seems clear that Justice Stevens' opinion concluded that the two-parent notice requirement without judicial bypass was unconstitutional because it failed some variant of the rational relationship test.

In my view, Justice O'Connor's opinion in *Hodgson* did not subject this requirement to a more exacting level of scrutiny. Although Justice O'Connor did not join Part III of Justice Stevens' opinion (in which he discussed the general constitutional standard that he applied), Justice

O'Connor wrote as follows (110 S. Ct. at 2949-50 (emphasis added)):

> It has been my understanding in this area that "[i]f the particular regulation does not 'unduly burde[n]' the fundamental right, . . . then our evaluation of that regulation is limited to our determination that the regulation rationally relates to a legitimate state purpose." . . . . *It is with that understanding that I agree with Justice Stevens' statement "that the statute cannot be sustained if the obstacles it imposes are not reasonably related to legitimate state interests."*

I interpret this to mean that Justice O'Connor agreed with Justice Stevens that the challenged statute should be judged under the rational relationship test. I do not think that she would have expressed general agreement with Justice Stevens' statement of the governing legal standard if she believed that the statute imposed an undue burden and was thus required to satisfy an entirely different legal standard. I also do not think that she would have concluded that the statute created an undue burden without explaining the basis for that conclusion. Moreover, Justice O'Connor joined Part VII of Justice Stevens' opinion, in which, as previously noted, Justice Stevens concluded that the two-parent notice requirement without judicial bypass was not "reasonably" related to any "legitimate interest." I do not think that Justice O'Connor would have joined this portion of Justice Stevens' opinion if her position regarding the constitutionality of the provision was based on a fundamentally different analysis. Thus, I conclude that Justice O'Connor found the two-parent notice statute unconstitutional under the rational relationship

test. This must mean either (a) that she did not believe that this requirement constituted an undue burden or (b) that she did not find it necessary to reach that question because she believed that the requirement could not even pass the rational relationship test. In either event, her position in no way undermines my conclusion that Section 3209 has not been shown to create an undue burden.[7]

III.

Since Section 3209 has not been proven to impose an undue burden, it must serve a "legitimate" (but not necessarily a "compelling") state interest. The majority acknowledges that this provision serves a "legitimate" interest, namely, the state's interest in furthering the husband's interest in the fetus. *See* majority typescript at 74, 77. I agree with this conclusion, and I do not think that this point requires extended discussion.

The Supreme Court has held that a man has a fundamental interest in preserving his ability to father a child. *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942). The Court's opinions also seem to establish that a husband who is willing to

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7. In the portion of her opinion concluding that the two-parent notification requirement with judicial bypass was constitutional, Justice O'Connor wrote (110 S.Ct. at 2950 (emphasis added)): "In a series of cases, this Court has explicitly approved judicial bypass as a means of tailoring a parental *consent* provision so as to avoid unduly burdening the minor's limited right to obtain an abortion." I interpret this statement to mean that a judicial bypass option prevents a consent requirement (which would otherwise amount to an absolute veto) from creating an undue burden. This statement is therefore fully consistent with my view that Justice O'Connor did not find that an undue burden was created by the two-parent *notice* requirement without judicial bypass.

participate in raising a child has a fundamental interest in the child's welfare. *Michael H. v. Gerald D.*, 491 U.S. 110, 123 (1989); *Quilloin v. Walcott*, 434 U.S. 246 (1978); *Caban v. Mohammed*, 441 U.S. 380 (1969); *Stanley v. Illinois*, 405 U.S. 645 (1972). It follows that a husband has a "legitimate" interest in the welfare of a fetus he has conceived with his wife.

To be sure, the Supreme Court held in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 67-72 (1976), that a potential father may not be given the legal authority to veto an abortion, and thus the Court apparently held that the potential father's interest was not "compelling." But the Court did not question the *legitimacy* of this interest. On the contrary, the Court wrote (*id.* at 69 (emphasis added)): "We are not unaware of the *deep and proper* concern and *interest* that a devoted and protective husband has in his wife's pregnancy and in the growth and development of the fetus she is carrying." *See also id.* at 93 (White, J., dissenting) ("A father's interest in having a child — perhaps his only child — may be unmatched by any other interest in his life"). Since a "deep and proper . . . interest" appears indistinguishable from a "legitimate" interest, it seems clear that a husband has a "legitimate" interest in the fate of the fetus.

This interest may be legitimately furthered by state legislation. "[S]tatutory regulation of domestic relations [is] an area that has long been regarded as a virtually exclusive province of the States." *Sosna v. Iowa*, 419 U.S. 393, 404 (1975). *See also Moore v. East Cleveland*, 431 U.S. 494, 499 (1977); *Scheinberg v. Smith*, 659 F.2d 476, 483-94 (5th Cir. 1981). Accordingly, Pennsylvania has a legitimate interest in furthering the husband's

interest in the fate of the fetus, as the majority in this case acknowledges.

IV.

The remaining question is whether Section 3209 is "rationally" or "reasonably" related to this interest. Under the rational relationship test, which developed in equal protection cases, "legislation carries with it a presumption of rationality that can only be overcome by a clear showing of arbitrariness and irrationality." *Hodel v. Indiana*, 452 U.S. 314, 331-32 (1981). This test does not permit the invalidation of legislation simply because it is "deemed unwise or unartfully drawn." *U.S. Railroad Retirement Board v. Fritz*, 449 U.S. 166, 175 (1981). Legislation does not violate this test simply because it produces some adverse effects. *Id.*; *Lindsley v. Natural Carbonic Gas Co.*, 220 U.S. 61-78 (1911). As the Court wrote in *Dandridge v. Williams*, 397 U.S. 471, 485-86 (1970):

> "The problems of government are practical ones and may justify, if they do not require, rough accommodations — illogical, it may be, and unscientific." *Metropolis Theatre Co. v. City of Chicago*, 228 U.S. 61, 68-70. . . .
>
> . . . [The rational-basis standard] is true to the principle that the Fourteenth Amendment gives the federal courts no power to impose upon the States their views of what constitutes wise economic or social policy.

See also Dallas v. Stanglin, 490 U.S. 19, 25-27 (1989); *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 439-40 (1985). Rather, "those challenging the legislative judgment must convince the Court that the legislative facts on which the classification

is apparently based could not reasonably be conceived to be true by the governmental decisionmaker." *Vance v. Bradley*, 440 U.S. 93, 111 (1979). *See also Hancock Industries v. Schaeffer*, 811 F.2d 225, 238 (3d Cir. 1987).

Even assuming that the rational relationship test is more demanding in the present context than in most equal protection cases, that test is satisfied here. The Pennsylvania legislature could have rationally believed that some married women are initially inclined to obtain an abortion without their husbands' knowledge because of perceived problems – such as economic constraints, future plans, or the husbands' previously expressed opposition – that may be obviated by discussion prior to the abortion. In addition, the legislature could have reasonably concluded that Section 3209 would lead to such discussion and thereby properly further a husband's interests in the fetus in a sufficient percentage of the affected cases to justify enactment of this measure. Although the plaintiffs and supporting amici argue that Section 3209 will do little if any good and will produce appreciable adverse effects, the Pennsylvania legislature presumably decided that the law on balance would be beneficial. We have no authority to overrule that legislative judgment even if we deem it "unwise" or worse. *U.S. Railroad Retirement Board v. Fritz*, 449 U.S. at 175. "We should not forget that 'legislatures are ultimate guardians of the liberty and welfare of the people in quite as great a degree as the courts.'" *Akron v. Akron Center For Reproductive Health*, 462 U.S. at 465 (O'Connor, J., dissenting), *quoting Missouri, K. & T. R. Co. v. May*, 194 U.S. 267, 270 (1904). Clearly, the plaintiffs have not shown that "the legislative facts on which [the statute] is

apparently based could not reasonably be conceived to be true by the governmental decisionmaker." *Vance v. Bradley*, 440 U.S. at 11. Thus, Section 3209 is rationally related to a legitimate state interest and may not be invalidated under the Supreme Court's abortion precedents.[8]

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8. The plaintiffs argue that the district court's decision may be affirmed on alternative constitutional grounds not adopted by that court, *i.e.*, that Section 3209 violates the rights to marital and informational privacy and equal protection. Because the majority has relied solely on the abortion right in affirming the district court, I do not address these alternative grounds.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, REPRODUCTIVE HEALTH AND ACTION COUNSELLING CENTER, WOMEN'S HEALTH SERVICES, INC., WOMEN'S SUBURBAN CLINIC, ALLENTOWN WOMEN'S CENTER, and THOMAS ALLEN, M.D., on behalf of himself and all others similarly situated,	:	CIVIL ACTION NO. 88-3228
Plaintiffs,	:	
v.	:	
ROBERT P. CASEY, N. MARK RICHARDS, ERNEST PREATE, personally and in their official capacities, and MICHAEL D. MARINO, personally and in his official capacity together with all others similarly situated,	:	
Defendants.	:	

OPINION

HUYETT, J. August 24, 1990

INTRODUCTION

This court is required to address again the difficult and controversial issue of the permissible degree of governmental regulation of a woman's abortion decision. In this action for declaratory and injunctive relief, plaintiffs challenge the 1988 and 1989 amendments to Pennsylvania's Abortion Control Act of 1982 ("the Act"), Act of March 25, 1988, 1988 Pa. Laws 262, No. 31, §§ 3-10 ("Act 31") and Act of November 17, 1989, 1989 Pa. Laws 592, No. 64, §§ 1-9 ("Act 64"), amending 18 Pa. Cons. Stat. Ann. §§ 3201-20 (Purdon 1983 and 1990 Supp.).[1] Plaintiffs assert that Act 31 and Act 64 violate the United States Constitution

1. Hereinafter, all citations to 18 Pa. Con. Stat. Ann. §§ 3201-20 refer to the amended Act, unless otherwise specified.

and 42 U.S.C. § 1983 (1981). I have subject matter jurisdiction over this controversy pursuant to 28 U.S.C. § 1331 (1966 and 1990 Supp.), 28 U.S.C. § 1343(a)(3),(4) (1976 and 1990 Supp.), and the fourteenth amendment to the United States Constitution.

Just three days prior to the scheduled effective date of Act 31, following a hearing, I granted plaintiffs' motion for a temporary restraining order and enjoined defendants from: (1) enforcing the provisions of section 3206[2] and

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2. Section 3206 of Act 31 required minor women seeking abortions in Pennsylvania to obtain informed parental consent therefor, or, in the alternative, to apply to the Court of Common Pleas of Pennsylvania for judicial authorization for an abortion. I concluded as follows:

> the evidence presented in numerous affidavits attached to the motion (continued...)

publicly disclosing or otherwise making available for public inspection and copying any report filed pursuant to

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2. (...continued)

> in affidavits presented at the hearing held on [April 21, 1988] establishes that the courts of common pleas of many counties in Pennsylvania have taken no steps to ensure that the provisions of Section 3206 are properly implemented. Specifically, as of this time there are no procedures in place in the courts of common pleas to ensure expedition of the proceedings or to ensure confidentiality. There is also substantial evidence in the record that no steps have been taken to ensure that individuals are available to provide legal representation for minors or to act as guardians ad litem. More importantly, it appears that key personnel in many of the courts of common pleas are unaware of the requirements of the statute. The Commonwealth failed to present any evidence which suggests that this situation will change before April 24, 1988.

See Temporary Restraining Order at ¶ 3 (April 21, 1988).

sections 3207(b) or 3214(f).[3] An evidentiary hearing and oral argument on plaintiffs' motion for a preliminary injunction was held on May 9, 1988. With the consent of the parties, I ordered that the earlier temporary restraining order would remain in effect until such time as I ruled on the motion for a preliminary injunction following the hearing. See Order (May 9, 1988). Two weeks later, on May 23, 1988, I preliminarily enjoined various portions of the Act.[4] Planned Parenthood

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3. Sections 3207(b) and 3214(f) of Act 31 required the public disclosure of certain reports, if the facility filing the report received state appropriated funds within the preceding twelve month period.

4. The various portions of the Act enjoined by my May 23, 1988 decision will be discussed below in the context of the sections of the Act at issue in this case.

of Southeastern Pennsylvania v. Casey, 686 F. Supp. 1089 (E.D. Pa. 1988). ("Casey I"). Defendants did not appeal this decision.

Thereafter, I stayed all proceedings pending issuance of the decision of the United States Supreme Court in Webster v. Reproductive Health Services.[5] At about the time of the Supreme Court's decision in Webster, the Pennsylvania legislature began debating various amendments to the Act. Several months later, on November 17, 1989, Act 64 was adopted to become effective in sixty days. With the consent of the defendants and leave of the court, plaintiffs filed an amended complaint to extend the scope of their challenge against the Act to include the 1989

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5. _____ U.S. _____, 109 S.Ct. 3040, 106 L.Ed. 2d 410 (1989).

amendments. After a conference held in chambers, I extended, over the objection of defendants, the preliminary injunction order to encompass the 1989 amendments to the Act. See Planned Parenthood of Southeastern Pennsylvania v. Casey, 736 F.Supp. 633 (E.D. Pa. 1990) ("Casey II").

The trial of this action on the merits was held during the week of July 30, 1990. The parties have entered into a comprehensive stipulation of uncontested facts and a supplemental stipulation of uncontested facts for the purposes of trial.[6] Based upon the stipulation of uncontested facts and the supplemental stipulation of uncontested

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6. These documents have been admitted into evidence and marked as Court's Exhibit 1 and the Court's Exhibit 1-A for ease of reference. All subsequent references to either document shall be by exhibit number and the relevant paragraph number.

facts, the evidence presented at trial, and the evidence presented at the hearing on plaintiffs' motion for a preliminary injunction which the parties have agreed would be admissible at the trial on the merits,[7] I make the following findings of fact and

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7. Specifically, I refer to the testimony and verifications of Sue Roselle, Sylvia Stengle, and Cathy Dratman, M.D. I note that defendants object to the admissibility of the verifications of these witnesses. However, these witnesses testified at the preliminary injunction hearing and were subject to cross-examination at that time. Therefore, defendants had ample opportunity to examine these witnesses concerning the contents of the verifications, as well as to object to the contents of the verifications. Further, Ms. Stengle and Ms. Roselle were included on defendants' witness list, see Defendants' Pretrial Brief at 4, and defendants could have called them to challenge their earlier testimony and verifications. Finally, Ms. Roselle testified at trial for plaintiffs and was subject to extensive cross-examination at that time. For these reasons, I overruled defendants' objection at the time of trial. See Pretrial Conference Transcript at 28-30.

conclusions of law. However, because in many ways the Pennsylvania legislature has come full circle by re-enacting many provisions of the Act which were deemed unconstitutional at various stages during the 1982 action involving the 1982 Act, I shall first summarize the lengthy history of abortion legislation in Pennsylvania.

I.

HISTORY OF ABORTION REGULATION IN PENNSYLVANIA[8]

In its landmark decision in Roe v. Wade, 410 U.S. 113, 93 S.Ct.

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8. For a more detailed discussion of this historical material, see Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 751-54, 106 S.Ct. 2169, 2173-75, 90 L. Ed. 2d 779 (1986) ("Thornburgh") and American College of Obstetricians and Gynecologists, Pennsylvania Section v. Thornburgh, 737 F.2d 283, 287-90 (3d Cir. 1984) ("American College II").

705, 35 L.Ed. 2d 147 (1973), the Supreme Court invalidated statutes, like Pennsylvania's,[9] containing general prohibitions against abortions, because such statutes unconstitutionally violated a woman's fundamental right to privacy. See also Doe v. Bolton, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed. 2d 201 (1973). In the year following Roe v. Wade, over the Governor's veto, the state legislature enacted Pennsylvania's first comprehensive "Abortion Control Act." See Abortion Control Act of 1974, 1974 Pa. Laws 639, No. 209 (amended 1978, repealed 1982). After

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9. Prior to Roe v. Wade, the relevant law in Pennsylvania provided that any person who "unlawfully" caused a woman's miscarriage committed a felony punishable by fine or imprisonment. See Penal Code of 1939, 1939 Pa. Laws 872, 958, No. 375, § 718, saved from repeal, Crimes Code of 1972, 1972 Pa. Laws 1482, 1611, No. 334, § 5 (repealed 1974). See American College II, 737 F.2d at 287 n.1.

extensive and substantial litigation, various provisions of the 1974 Act, including sections relating to spousal and parental consent to abortion procedures, to the proscription of advertising for abortion procedures, to the choice of post-viability abortion procedures, and to the criminal standard governing the performance of abortions at viability, were struck down. See Planned Parenthood Ass'n v. Fitzpatrick, 401 F. Supp. 554 (E.D. Pa. 1975) (three judge panel), aff'd mem. in part sub nom., Franklin v. Fitzpatrick, and vacated and remanded mem. in part sub nom., Beal v. Franklin, 428 U.S. 901, 96 S.Ct. 3202, 49 L.Ed. 2d 1205 (1976), modified on remand, Civil Action No. 74-2440 (E.D. Pa. Sept. 16, 1977) (unreported), aff'd sub nom., Colautti v. Franklin, 439 U.S. 379, 99 S.Ct. 675,

58 L.Ed. 2d 596 (1979).[10] See also Doe v. Zimmerman 405 F. Supp. 534 (M.D. Pa. 1975) (three judge panel).

In 1978, the legislature attempted to restrict a woman's access to abortions by limiting medical assistance funding for the procedure. See Act of September 26, 1978, 1978 Pa. Laws 773, No. 148, §§ 1-2. A successful challenge was mounted against this effort. Roe v. Casey, 464 F. Supp. 487 (E.D. Pa. 1978), aff'd, 623 F.2d 829 (3d Cir. 1980).

Thereafter, a bill based on a model developed by Americans United For Life, a non-profit organization, was introduced by the House as an amendment to a Senate bill regulating "tough guy"

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10. For a summary of the history of the cases involving the Abortion Control Act of 1974, see Colautti v. Franklin, 439 U.S. at 384-86, 99 S.Ct. at 679-80.

competitions. See Note, Toward Constitutional Abortion Control Legislation: The Pennsylvania Approach. 87 Dick. L. Rev. 373, 382 n.84 (1983). Despite being rejected by the relevant legislative committee, the bill was passed overwhelmingly. The Senate, after brief discussion, concurred with the House amendment. While acknowledging his personal opposition to abortion, Dick Thornburgh, then Governor of Pennsylvania, vetoed the bill and explained his action as follows:

> I am concerned that [some] provisions, and to some extent, the overall tone and tenor of the bill, would have the effect of imposing an undue, and, in some cases, unconstitutional burden upon even informed, mature adults intent upon obtaining an abortion under circumstances in which the U.S. Supreme Court has determined they are entitled to do so. . . .

> Likewise, I am concerned that some of the detailed, complex and burdensome requirements of the bill, accompanied as they are by severe criminal penalties, could well foster an atmosphere in which many physicians would be deterred from providing the kind of abortion-related medical services to which the U.S. Supreme Court has held their patients are constitutionally entitled. This could well disrupt the traditional doctor-patient relationship and impinge upon the right of physicians to practice. Of even greater concern is the potential for more experienced and conscientious physicians to refrain from involvement in even medically necessary abortions, and to abandon the field to marginal practitioners. It could even lead to a resurgence of "back alley" abortions, which no thoughtful person would wish to happen. . . .
>
> I am also concerned that in its entirety the bill in its current form goes further than is necessary in protecting the state interests in this area . . . . In so doing, it threatens to create additional regulation and bureaucracy and to unduly involve government in the private lives of its citizens.

See Veto Message to the Senate at 7 (December 23, 1981) [Plaintiffs' Exhibit

60]. After revision and introduction on the floor of the House as an amendment to a bill relating to paramilitary training, the Abortion Control Act of 1982 was passed by both the House and Senate. Signed by Governor Thornburgh on June 11, 1982, the Act was to take effect within 180 days, on December 8, 1982, from its enactment.

The Abortion Control Act of 1982 imposed detailed regulations on abortions which required that: (1) a pregnant woman wait a mandatory 24 hours prior to undergoing an abortion procedure after giving her consent to the procedure; (2) a physician personally provide certain specified information to a woman seeking an abortion as a part of the informed consent process; (3) unemancipated minors obtain parental or judicial

consent for an abortion procedure; and (4) all second trimester abortions be performed in a hospital. The 1982 Act also strictly limited post-viability abortions; dictated the use of specific procedures and, in some cases, the presence of a second physician to save the aborted fetus; imposed detailed reporting regulations; required fetal pathology reports; restricted the availability of public funds for the performance of abortions; and regulated private insurance coverage for the performance of abortions. Further, the 1982 Act subjected physicians and clinics violating the Act to criminal prosecution, as well as civil tort liability and revocation or suspension of licensure.

Before the Act took effect, the American College of Obstetricians and

Gynecologists ("ACOG"), Pennsylvania Section, various abortion clinics and physicians, among others, filed suit in this court alleging that the 1982 Act was unconstitutional in its entirety and immediately filed a motion for a preliminary injunction. See American College of Obstetricians and Gynecologists, Pennsylvania Section, et al. v. Thornburgh, et al., Civil Action No. 82-4336. Based upon what the Third Circuit later described as "an unusually complete factual and legal presentation from which to address the important constitutional issues at stake," see American College II, 737 F.2d at 290, I concluded that the 1982 Act as a whole was constitutional with the exception of the 24-hour waiting period contained in section 3205. American College of Obstetricians and Gynecologists,

Pennsylvania Section v. Thornburgh, 552 F. Supp. 791 (E.D. Pa. 1982) ("American College I").

Plaintiffs immediately filed a notice of appeal, and the Commonwealth filed a cross-appeal challenging my ruling on the 24-hour waiting period provision. The Third Circuit, on December 9, 1982, granted the plaintiffs' motion for stay of enforcement of the entire Act pending appeal. After expedited briefing and argument, the Third Circuit withheld opinion pending three decisions of the Supreme Court which were under submission.[11] After consideration of

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11. City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416, 103 S.Ct. 2481, 76 L.Ed. 2d 687 (1983) ("Akron"); Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft, 462 U.S. 476, 103 S.Ct. 2517, 76 L.Ed. 2d 733 (1983) ("Ashcroft"); Simopoulos v. Virginia, 462 U.S. 506, 103 S.Ct. 2532, 76 L.Ed. 2d 755 (1983).

supplemental briefs and reargument, the Third Circuit ruled that various sections of the 1982 Act were unconstitutional, including the detailed reporting provisions imposed upon physicians, the requirement of discriminatory insurance, the compulsory "informed consent" information which must be given to a pregnant woman seeking an abortion, and the sections attempting to control the method of abortion and mandate the attendance of a second physician under certain circumstances. American College II, 737 F.2d at 283. Further, in light of the decisions in Akron and Ashcroft, the Commonwealth conceded, and the Third Circuit agreed, that the 24-hour waiting period, the physician-only disclosure requirements, and the proscription against second trimester abortions unless performed in a hospital were

unconstitutional. Id. at 293. The Supreme Court subsequently affirmed by a five to four vote. Thornburgh, 476 U.S. at 747, 106 S.Ct. at 2169.[12]

Thereafter, Pennsylvania's legislature adopted the 1988 and 1989 amendments to the Act. These amendments include many provisions similar, if not identical, to the provisions of the 1982

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12. Subsequent to the Third Circuit's decision, I enjoined, upon motion of the plaintiffs, the enforcement of the public disclosure provisions of the 1982 Act. American College of Obstetricians and Gynecologists, Pennsylvania Section v. Thornburgh, 613 F. Supp. 656 (E.D. Pa. 1985) ("American College III"). The Supreme Court declined to reach this issue. Thornburgh, 476 U.S. at 758 n.9, 106 S.Ct. at 2177 n.9. Further, after the Supreme Court's decision in Thornburgh, I continued the preliminary injunction as it applied to the rules promulgated by the Pennsylvania Supreme Court governing the judicial by-pass procedure for minors seeking an abortion. See American College of Obstetricians and Gynecologists, Pennsylvania Section v. Thornburgh, 656 F. Supp. 879 (E.D. Pa. 1987) ("American College IV").

version of the Act struck down by this court, the Third Circuit, and the United States Supreme Court, as well as other provisions to which plaintiffs object. These include a mandatory 24-hour waiting period for all women seeking to have an abortion; a parental informed consent/judicial by-pass procedure for minor women seeking to terminate their pregnancy; spousal notification provisions; physician-only disclosure requirements; and various reporting and disclosure requirements.[13]

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13. Prior to the enactment of the 1988 amendments, Governor Casey vetoed an earlier version of the 1988 amendments, but identified a need for the "strongest possible measure [of] controlling abortion consistent with the Constitution and [his] oath to it." See Veto Message to the House at 2 (December 17, 1987) [Plaintiffs' Exhibit 62]. In so doing, Governor Casey, "opposed to abortion on every moral ground," recognized the invalidity of physician-only counseling requirements (continued...)

II.

FINDINGS OF FACT

A. The Parties and Witnesses.

1. Plaintiff Thomas Allen testified as an expert at trial in the field of obstetrics and gynecology. He is qualified to testify as an expert in this field, and I found his testimony to be credible in all respects. Dr. Allen is a physician licensed to practice

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13. (...continued)
and further stated:

> Other rulings by the [Supreme] Court have declared that a state may not compel disclosure of information protected by an individual's right of privacy to any third-party; that a state lacks a legally justifiable interest in simply knowing the identity of a woman seeking an abortion; and that a state cannot intervene in a marital relationship to dictate the relationships between husband and wife. In striking down spousal consent requirements, the Court has held that a state cannot delegate to any third-party -- even a husband -- the power that the state cannot exercise itself.

Id. at 5 (emphasis supplied).

medicine in Pennsylvania and is an Associate Clinical Professor in the Department of Obstetrics and Gynecology at the University of Pittsburgh. He graduated from the University of Pittsburgh School of Medicine in 1943. He is an emeritus staff member of Magee Women's Hospital, and is Medical Director of Women's Health Services, Inc. He has been a Diplomate of the American College of Obstetrics and Gynecology since 1954, has been a Fellow of the American College of Obstetrics and Gynecology since 1955, and a Fellow of the Pittsburgh Obstetrical and Gynecological Society since 1974. From 1972 to the present, Dr. Allen has been active in planning, establishing and administering Women's Health Services, Pittsburgh's first free standing

abortion clinic. From 1970 to 1979, he was active in establishing and contributing services to the Pittsburgh Free Clinic. Dr. Allen has a private obstetrical and gynecological practice with one other specialist. [Court's Exhibit 1 at ¶ 1; Plaintiffs' Exhibit 81; Trial Testimony of Dr. Allen, Vol. I at 35-39].

2. Plaintiff Planned Parenthood of Southeastern Pennsylvania ("PPSP") is a non-profit corporation providing comprehensive family planning, medical and counseling services (including birth control education), pregnancy testing and counseling, gynecological care, first trimester abortions, and vasectomies at medical clinics in Philadelphia, Montgomery and Delaware Counties. The Center City Philadelphia

clinic offers these services Monday through Friday. Abortions are performed on Wednesdays, Thursdays, Fridays and Saturdays at PPSP's Center City Philadelphia Clinic. [Court's Exhibit 1 at ¶2].

3. Plaintiff Reproductive Health and Counseling Center ("RHCC") is a for-profit corporation in Chester, Pennsylvania, which operates a clinic that performs first and early second trimester abortions. [Court's Exhibit 1 at ¶ 12].

4. Plaintiff Women's Health Services, Inc. ("WHS") in Pittsburgh, Pennsylvania, is a non-profit health center providing fertility control education, pregnancy counseling, general counseling for individuals and couples, PMS counseling and treatment, contraceptive and gynecological care,

public education, and first and early second trimester abortions. [Court's Exhibit 1 at ¶ 25].

5. Plaintiff Women's Suburban Clinic ("WSC") is a non-profit corporation in Paoli, Pennsylvania, which operates a health care facility providing abortions, ongoing gyneco-logical services, mini-laparoscopies, pregnancy testing, community education, and other counseling services. [Court's Exhibit 1 at ¶ 42].

6. Plaintiff Allentown Women's Center ("AWC") is a for-profit corporation in Allentown, Pennsylvania, which operates a clinic providing pregnancy testing and counseling, contraceptive and gynecological care, and first trimester abortions. [Court's Exhibit 1 at ¶55].

7. Defendant Robert P. Casey is the

Governor of the Commonwealth of Pennsylvania. [Plaintiffs' Amended Complaint and Defendants' Answer to Amended Complaint at ¶13].

8. Defendant N. Mark Richards, M.D., is the Secretary of Health of the Commonwealth of Pennsylvania. [Plaintiffs' Amended Complaint and Defendants' Answer to Amended Complaint at ¶14].

9. Defendant Ernest Preate, Jr., is the Attorney General of the Commonwealth of Pennsylvania. [Plaintiffs' Amended Complaint and Defendants' Answer to Amended Complaint at ¶15].

10. Defendant Michael D. Marino is the District Attorney for Montgomery County, Pennsylvania.[14] [Plaintiff's

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14 By stipulation filed on July 24, 1990, the parties have voluntarily dismissed defendant Marino from this action pursuant to Rule 41(a)(1) of the Federal Rules of Civil Procedure.

Amended Complaint and Defendants' Answer to Amended Complaint at ¶ 16].

11. Sue Roselle testified at the hearing on plaintiffs' motion for a preliminary injunction and at trial. I found her testimony on both occasions to be credible in all respects. Ms. Roselle is the Executive Director of WHS. As Executive Director, she is responsible for the ongoing operation of the clinic and for staff selection, and she reports to the Board of Directors of WHS. She holds a master's degree in social work from the University of Illinois at Urbana, and a M.S.B.A. in management from Robert Morris College. She is Treasurer of the Pennsylvania Chapter of the National Association of Social Workers, a member of the Academy of Certified Social Workers, President

of Pennsylvanians for a Right to a Private Life, and serves on the Health Services Committee of the American Red Cross, Pittsburgh-Allegheny Chapter. She has over ten years' experience in health care administration, including medical services and home health care. She is a former director for emergency medical service systems for the 12 counties of southwestern Pennsylvania. [See Casey I, 686 F.Supp. at 1093 (¶ 11)].

12. Sylvia Stengle testified at the hearing on plaintiffs' motion for a preliminary injunction. I found her testimony to be credible in all respects. Ms. Stengle is the founder and Director of AWC. She is responsible for the ongoing operation of the clinic and hiring. She holds a bachelor's degree from the University of Wisconsin, and has taken graduate courses in

sociology and psychology. Prior to founding AWC in 1978, she was the Education Director for Planned Parenthood of Northampton County, Pennsylvania. She has been personally involved in counseling since 1973, and now supervises the AWC counseling staff. She serves on the Board of Directors of the national Abortion Rights Action League. [See Casey I, 686 F. Supp. at 1093-94 (¶ 12)].

13. Dr. Cathy Dratman testified at the hearing on plaintiffs' motion for a preliminary injunction. I found her testimony to be credible in all respects. Dr. Dratman is licensed to practice medicine in Pennsylvania and New Jersey. She is a graduate of Hahnemann Medical College, and completed her internship and residence at Pennsylvania Hospital in Philadelphia.

She is board certified by the American Board of Obstetrics and Gynecology. She has been Medical Director of PPSP since 1986, and has a private obstetrical and gynecological practice in New Jersey. She does not presently perform abortions, but in the past has performed and referred patients for first and second trimester abortions up to 20 weeks gestation. As Medical Director of PPSP, she maintains close contact with, and generally oversees, all abortion procedures performed at the clinic. [Casey I, 868 F. Supp. at 1094 (¶ 13)].

14. Dr. Steven J. Davidson testified at trial as an expect in the field of emergency medicine. He is qualified to testify as an expert in emergency medicine, and I found his testimony credible in all respects. Dr. Davidson is a physician licensed to

practice medicine in Pennsylvania and California. He is a Division Head of Pre-Hospital Care and Professor of Emergency Medicine at the Medical College of Pennsylvania where he teaches, both clinically and didactically, medical students, interns, residents and house staff. He received his bachelor's degree in chemistry with honors from Temple University in 1971 and graduated from Temple University Medical School in 1975. Dr. Davidson's internship and residency, in emergency medicine, took place in the Medical College of Pennsylvania. Subsequently, he was awarded a master's degree in business administration from the Wharton School of the University of Pennsylvania in 1989.

Dr. Davidson's hospital appointments include attending physician at the

hospital at the Medical College of Pennsylvania, associate in the Department of Emergency Medicine at the Mercy Catholic Medical Center, and he serves on the intensive care unit, attending staff and affiliate staff, at Jefferson Hospital. He presently sees patients in emergency rooms approximately 600 hours annually.[15] He has been a Fellow of the American College of Emergency Physicians since 1982, and has been a Diplomate of the American Board of Emergency Medicine since 1980. Finally, he is the author or co-author of numerous publications and has given numerous presentations on topics in the field of emergency

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15 A full-time clinical practice in emergency medicine is generally considered to encompass approximately 2,000 hours of practice a year. [Trial Testimony of Dr. Davidson, Vol. I at 12].

medicine. [Trial Testimony of Dr. Davidson, Vol. I at 10-14; Plaintiffs' Exhibit 77].

Dr. Michael Alan Grodin testified at trial as an expert in the field of medical ethics. He is qualified to testify as an expert in medical ethics, and I found his testimony credible in all respects. Dr. Grodin is a physician licensed to practice medicine in Massachusetts and New York. He received his bachelor's degree from Massachusetts Institute of Technology in 1973 and graduated from Albert Einstein College of Medicine in 1976. Dr. Grodin was an intern and junior resident in pediatrics at Harbor General Hospital in Torrance, California (UCLA), and completed his residency in pediatrics at Massachusetts General Hospital and Boston City Hospital (Harvard University). While at Boston City Hospital, he was Chief

Resident in Pediatrics. Subsequently, he completed a clinical fellowship in pediatric cardiology at Children's Hospital Medical Center in Boston.

Dr. Grodin is a pediatrician and a professor with over eleven years of experience in the field of medical ethics. He has taught courses and lectured within the Boston University Schools of Liberal Arts, Medicine, Law, Public Health, Social Work, and Theology over the past eleven years. He is presently Associate Director of the Law, Medicine and Ethics Program and Director of Medical Ethics at Boston University Schools of Medicine and Public Health, where he is also Associate Professor of Health Law, Pediatrics, and Socio-Medical Sciences and Community Medicine. In addition, he is Adjunct Associate Professor of Philosophy in the

college of Liberal Arts at Boston University.

Dr. Grodin is a Medical Ethicist and Human Studies Chairman for the Department of Health and Hospitals of the City of Boston, and serves on the Institutional Review Board and Ethics Advisory Group-Institutional Ethics Committee of Boston City Hospital. He is a staff pediatrician at Associated Pediatricians of Boston, an associate visiting pediatrician at Boston City Hospital, and a senior associate in pediatrics at Beth Israel Hospital in Boston. In addition, he serves on the boards of directors of the American Society of Law and Medicine, and Public Responsibility in Medicine and Research. He is a member of the National Committee on Bioethics of ACOG. Finally, he served as medical ethics reviewer for The New England

Journal of Medicine and Oxford University Press, authored or co-authored numerous publications in the areas of moral dilemmas in medicine and problematic decision-making in clinical medicine, and has delivered numerous presentations on various topics in the field of medical ethics. [Trial Testimony of Dr. Grodin at 91-96; Plaintiffs' Exhibit 78].

16. Dr. Ronald J. Bolognese testified at trial as an expert in the fields of obstetrics, gynecology and perinatal medicine. He is qualified to testify as an expert in these areas, and I found his testimony credible in all respects. Dr. Bolognese is a physician licensed to practice medicine in Pennsylvania and New Jersey. He received his bachelor's degree from Princeton University in 1959 and graduated from the University of

Pennsylvania School of Medicine in 1967. Dr. Bolognese completed his internship at Bryn Mawr Hospital and his residency in obstetrics and gynecology at Pennsylvania Hospital in Philadelphia.

Dr. Bolognese was the Chief of Obstetrics and Gynecology at Williams Air Force Base Hospital in Arizona from 1967 to 1969. He has specialty certifications from ACOG and the Maternal-Fetal Medicine Board, a division of ACOG.[16] He is the Director of the Section on Perinatology of the Department of Obstetrics and Gynecology at Pennsylvania Hospital. Since 1985, he has been the Chairman

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16. In 1974, ACOG established the subspecialty of perinatology, which is maternal fetal medicine or high risk obstetrics, for physicians with additional training and expertise in this area. Dr. Bolognese was one of the original fourteen physicians certified in this subspecialty. [Trial Testimony of Dr. Bolognese, Vol. I at 139-140].

of the Department of Obstetrics and Gynecology at Pennsylvania Hospital. He has been a Professor of Obstetrics and Gynecology at the University of Pennsylvania School of Medicine since 1982, after serving as a clinical assistant professor and associate professor of obstetrics and gynecology. Finally, he is the author or co-author of numerous publications and has delivered several presentations on topics in his fields of expertise. [Trial Testimony of Dr. Bolognese, Vol. I at 137-141; Plaintiffs' Exhibit 79].

17. Dr. Lenore E. A. Walker testified at trial as an expert in the field of family violence. She is qualified to testify as an expert in the area of family violence and the effects of battering on women, children and other members of their families and I found her testimony credible in all

respects. Dr. Walker is licensed to practice psychology in Colorado and New Jersey. She received her bachelor's degree in psychology from Hunter College of the City University of New York in 1962, her master's degree in clinical school psychology from City College of the City University of New York in 1967, and her doctorate degree from Rutgers University's School of Psychology in 1972.

Dr. Walker has more than twenty years of experience as a licensed clinical, forensic, and school psychologist. She is currently the president of Walker and Associates in Denver and the founder and Executive Director of the Domestic Violence Institute, a non-profit organization which conducts research in the area of family violence. Dr. Walker is a Fellow of and has served on the council of

Representatives of the American Psychological Association and as chair of its Women's Caucus. In 1987, she was the recipient of the Board of Professional Affairs Distinquished Professional Contributions to Psychology in the Public Interest Award, one of the American Psychological Associations highest honors. Dr. Walker is also an adjunct professor of psychology at the University of Denver. During her career she has been Chairperson of the Department of Psychology and Associate Professor of Psychology at Colorado's Women's College, an Assistant Professor of Psychiatry at Rutgers University's Medical School, and an Assistant Professor at Rutgers University's Graduate School of Applied and Professional Psychology.

Dr. Walker was one of the first scientists in the country to conduct

clinical research on intra-family violence and is one of the foremost experts on the psychology of battered women and families. From 1978 to 1981, she acted as the principal investigator for a National Institute for Mental Health funded study on the "battered women syndrome." She is the author or co-author of numerous publications, including The Battered Woman, her first book published in 1979 for which she received a Distinguished Media Award from the Association for Women in Psychology. She serves as an assistant editor for a number of major "referree" journals[17] in her field, has delivered several presentations on topics in her

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17. "Referee" journals are publications in which all articles are subjected to peer review to determine worthiness for publication prior to publication. [Trial Testimony of Dr. Walker, Vol. II at 8."

field, and consulted with governmental agencies and testified, in criminal and civil cases in thirty states and federal courts, as an expert on domestic violence and the battered women syndrome. [Trial Testimony of Dr. Walker, Vol. II at 3-9; Plaintiffs' Exhjibit 80].

18. Jean A. Dillon[18] testified at trial, and I found her testimony credible in all respects. She is a counselor for Women's Resource Center of Monroe County, Inc., a non-profit

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18. In an oral motion in limine, defendants objected to the testimony of Ms. Dillon on several grounds and sought to exclude her from testifying at trial. At the pretrial conference, I orally denied defendants' motion in limine. See Pretrial Conference Transcript at 5-16. Subsequently, I issued an order memorializing my denial of defendants' motion and explaining my reasons therefor. See Order (July 31, 1990). I incorporate herein by reference my ruling at the pretrial conference and in my July 31, 1990 order herein by reference.

organization that provides counseling services to battered women, victims of sexual abuse, and children in domestic violence situations. Women's Resource Center of Monroe County is a member organization of the Pennsylvania Coalition Against Domestic Violence which provides similar services to battered women and children. Ms. Dillon provides protection from abuse accompaniment for battered women and children to courthouses, shelters women in need of a safe house, and spends many hours working on a crisis intervention hotline annually. Also, she is a former victim of spousal abuse. [Trial Testimony of Ms. Dillon, Vol. III at 143-165].

19. Dr. Vincent M. Rue testified at trial as an expert in the areas of problem pregnancy decision-making,

marital family relationships, and psychological effects following an abortion. Dr. Rue received a bachelor's degree in sociology from St. John's University, a master's degree in clinical social work from St. Louis University, and doctorate degree in family relations from the University of North Carolina, School of Home Economics at Greensboro. He is co-founder and co-director of the Institute for Abortion Recovery and Research in New Hampshire, and Executive Director of Sir Thomas Moore Clinic in California. In addition, from 1975 to 1980, he was an Associate Professor of Family Relations at the School of Fine and Applied Arts of California State University at Los Angeles, and was an Adjunct Associate

Professor at the School of Professional Psychology at United States International University in San Diego.

Dr. Rue is a licensed marriage and family counselor in California, and a trained psychotherapist. He is not a psychologist and has never conducted a controlled research study. While Dr. Rue has produced various published works in his field, he has never had any of his work published in a referee journal. Because he is not a physician, Dr. Rue has never provided informed consent for an abortion or any other medical procedure. In addition, he has not conducted any research on the informed consent procedures utilized in abortion clinics in Pennsylvania. [Trial Testimony of Dr. Rue, Vol. II at 143-155; Defendants' Exhibit 62].

Dr. Rue submitted a study he co-authored with others, The

Psychological Aftermath of Abortion, to Surgeon General C. Everett Koop and the House of Representatives Committee on Government Operations as part of a federal investigation of the medical and psychological effects of abortion which purports to establish the existence of a psychological disorder denominated "post abortion syndrome." After submission for peer review by scientists with the Center for Disease Control, the National Center for Health Statistics and other scientific institutions, his study was found to have "no value" and to be "based upon a priori briefs rather than an objective review of the evidence." See The Federal Role in Determining the Medical and Psychological Impact of Abortion on Women, Committee on Government Operations, H.R. 101-392, 101st Cong. 1st Sess. (Dec. 11, 1989) at 12 [Plaintiffs' Exhibit 67 at 12].

The Board of Directors of the American Psychological Association, after review of all of the scientific literature, has determined that there are no scientific studies which support the existence of a "post abortion syndrome" as suggested by Dr. Rue. [Trial Testimony of Dr. Rue, Vol. II at 51].

Because Dr. Rue lacks the academic qualifications and scientific credentials possessed by plaintiffs' witnesses, I conclude that his testimony, which is based primarily, if not solely, upon his limited clinical experience, is not credible. His testimony is devoid of the analytical force and scientific rigor which typified the testimony of plaintiffs' expert psychologist, Dr. Walker. Moreover, his admitted personal opposition to abortion, even in cases of rape and incest, suggests a possible

personal bias. Finally, his testimony concerning informed consent is suspect in light of his lack of direct involvement in obtaining informed consent for any medical treatment or procedure.

20. Dr. Watson Allen Bowes, Jr., testified at trial as an expert in the fields of high risk obstetrics and maternal fetal medicine. He is qualified to testify as an expert in these fields, and I found his testimony credible in certain respects but subject to certain limitations caused by his admitted philosophical opposition to abortion.[19] In addition, because Dr.

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19. Dr. Bowes testified that he would not perform an abortion under any circumstances except when the life of the mother is threatened. Further, he has been a member of the American Association of Pro-Life Obstetricians, an organization of obstetricians and gynecologists opposed to the performance (continued ...)

Bowes is not a certified specialist in emergency medicine, like Dr. Davidson, his testimony on issues pertaining to this area is not entitled to the same weight as the testimony of Dr. Davidson.

Dr. Bowes is a physician licensed to practice medicine in North Carolina and Colorado. He received his bachelor's degree from Washington and Lee University in 1955 and graduated from the University of Colorado School of Medicine in 1959. Dr. Bowes completed his internship at Mary Hitchcock Memorial Hospital, his residency (general practice) at the University of Colorado, and his residency (obstetrics and gynecology) at the University of Colorado School of Medicine. In addition,

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19. (... continued)
of abortions except where necessary to save the life of the mother. [Trial Testimony of Dr. Bowes, Vol. III at 30-31].

he was a Fellow in Obstetrics and Gynecology, Reproductive Physiology Laboratory at the University of Colorado School of Medicine.

Dr. Bowes is certified by ACOG, as well as ACOG's Division of Maternal-Fetal Medicine. He is presently a Professor in the Department of Obstetrics and Gynecology at the University of North Carolina School of Medicine at Chapel Hill. Previously, he taught obstetrics and gynecology at the University of Colorado as an assistant professor, associate professor and full professor. Finally, he is the author of various publications in his field. [Trial Testimony of Dr. Bowes, Vol. III at 25-32; Defendants' Exhibit 61].

21. Patricia Potrzebowski, Ph.D., testified at trial, and I found her

testimony credible in all respects. She is the Director of the Division of Health Statistics and Research, State Health Data Center, Department of Health. She has a bachelor's degree in biology from Schimer College, Mount Carroll, Illinois. In 1974, she obtained a doctorate degree in human genetics from the Graduate School of Public Health from the University of Pittsburgh. She has been the Director of the Division of Health Statistics since late 1976 or early 1977. [Trial Testimony of Dr. Potrzebowski, Vol. III at 88-90; see also Casey I, 686 F. Supp. at 1094 (¶ 14)].

B. Procedures and Practices of Plaintiffs.

(1) Planned Parenthood of Southeastern Pennsylvania

22. PPSP performs approximately 2,800 first trimester abortions a year.

The abortion procedure presently costs full-payment patients $240, if the woman is 12 weeks or less from her last menstrual period. All fees cover only the direct costs of the procedure, including personal counseling, medical testing and examination, the abortion procedure, medical supervision during the post-surgical recovery, and a post-abortion examination. [Court's Exhibit 1 at ¶ 3].

23. PPSP charges $180 for abortions for women who are on medical assistance but whose abortions are not reimbursable by the state. [Court's Exhibit 1 at ¶ 4].

24. PPSP accepts state medical assistance reimbursement in lieu of direct payment for abortions for victims of rape and incest, and for women with life-threatening conditions. In 1987,

approximately 53 of the abortions performed at PPSP were reimbursed by the Commonwealth. [Court's Exhibit 1 at¶ 5].

25. When a woman believing she is pregnant presents herself at a PPSP clinic, she is given a pregnancy test and examined by a nurse practitioner or physician. Women who believe they have just recently become pregnant are offered early detection by means of a blood test or special urine test. Once it is determined that she is pregnant, the woman is encouraged to participate in an individual options counseling session with a PPSP counselor. [Court's Exhibit 1 at ¶ 7].

26. Options counselors are volunteers or staff counselors who have completed a special training program under the supervision of PPSP counselors and other senior staff members. This

training program consists of 43 hours of group sessions that focus on factual information regarding adoption, abortion, contraception and referral resources. The course also gives participants the opportunity to evaluate, explore and share their attitudes and feelings. The course is certified by Temple University, and participants receive four CEU credits for completion of the training. [Court's Exhibit 1 at ¶ 8].

27. Abortion counselors are members of PPSP's counseling staff or college student interns working under the supervision of a staff counselor. These counselors have college backgrounds and experience in a health or social services related field. All abortion counselors have had on-site training in pregnancy counseling and abortion care

and are required to participate in ongoing in-service training. [Court's Exhibit 1 at ¶ 9].

28. Each PPSP client participates in an individual abortion counseling session on the day her procedure is scheduled. In this session, the counselor and the woman discuss the woman's medical history, personal situation and feelings about abortion. The counselor explains the abortion procedure and its risks. Post-abortion care and contraceptive plans are also explored. If the client has been accompanied to the clinic by a person she wishes to involve in the counseling, that person will be included in part of this session. In some cases the abortion counselor will serve as the support person and accompany the woman through the procedure. [Court's Exhibit 1 at ¶ 10].

29. To assure that minors are informed of all options and are making a free and informed choice, PPSP counseling sessions for minors are more extensive. In the course of the counseling session, minors are given detailed information on the procedure and its risks. Minor women are also counseled on future contraceptive care. When a minor does elect to involve a parent or other supportive adult such as an aunt, guardian or older sibling, the counselor will first meet privately with the minor. Then, at the counselor's discretion and with the minor's consent, the parent or adult will be brought in for joint counseling. [Court's Exhibit 1 at ¶ 11].

30. Many of PPSP's abortion patients come from referrals from other clinics where they previously have

received options counseling. [Court's Exhibit 1-A at ¶ 115].

31. During options counseling at PPSP, the counselors discuss with the woman the option of keeping her baby or giving it up for adoption. [Court's Exhibit 1-A at ¶ 116].

32. It is typical for a woman to receive counseling about her options once she has her pregnancy diagnosed at one of PPSP's centers, and to receive counseling again at the surgical center in Center City. [Court's Exhibit 1-A at ¶ 123].

33. In 1987, PPSP performed 359 abortions for women under the age of 18. [Court's Exhibit 1 at ¶ 6].

34. PPSP encourages minors to bring a parent with them. [Court's Exhibit 1-A at ¶ 114].

35. Approximately 65% of the minors

bring a parent with them to the counseling session in PPSP's experience. [Court's Exhibit 1-A at ¶ 117].

36. PPSP refers women with medical problems that make them high-risk patients to hospitals. [Court's Exhibit 1-A at ¶ 113].

37. PPSP advises minors (and others) that if anything unusual or any sort of complications occur to let PPSP know and come back for treatment or to go to an emergency room for treatment. [Court's Exhibit 1-A at ¶ 124].

38. PPSP collects information for its internal use concerning medical complications following an abortion. [Court's Exhibit 1-A at ¶ 122].

(2) Reproductive Health and Counselling Center

39. RHCC performs approximately 2,900 first and early second trimester

abortions annually. [Court's Exhibit 1 at ¶ 12].

40. RHCC employs a staff of approximately four physicians, one nurse practitioner, and two full-time and two part-time counselors. Abortions are performed on Tuesday, Wednesday and Friday afternoons. Additional counseling sessions are available by appointment. [Court's Exhibit 1 at ¶ 13].

41. At RHCC, one physician works at a time during those hours of operation when abortions are performed. [Court's Exhibit 1-A at ¶ 141].

42. First trimester abortions (up to 12 weeks from the last menstrual period) with local anesthesia cost RHCC clients $220. For abortions from 12 to 16 weeks from the last menstrual period the cost is $375, plus an additional $70

for a required ultrasound. [Court's Exhibit 1 at ¶ 14].

43. If RHCC's clients are eligible for medical assistance reimbursement, RHCC seeks reimbursement from the Commonwealth. In 1987, RHCC was reimbursed for no more than 20 suchabortions. The reimbursement rate was $59.50 to the clinic and $81.50 to the physician. [Court's Exhibit 1 at ¶ 15].

44. Where a client receives medical assistance from the state but is not eligible for medical assistance for an abortion, RHCC provides a $50 cost reduction for first trimester abortions with local anesthesia. [Court's Exhibit 1 at ¶ I6].

45. While RHCC's clients come primarily from Delaware, Philadelphia, Chester and Bucks Counties,

approximately 3-4% of its clients come from areas in excess of three hours travelling time. [Court's Exhibit 1 at ¶ 17].

46. A woman's first contact with RHCC is usually by telephone. Women who call RHCC may or may not have had a pregnancy test prior to calling. Telephone counselors refer the women to RHCC or to the agency closest to her home or place of work for the test. [Court's Exhibit 1 at ¶ 19].

47. If a woman has a positive pregnancy test and wants to terminate the pregnancy, RHCC will schedule an abortion appointment, usually within one week's time. If the woman indicates uncertainty about her decision, the telephone counselor will recommend her making an appointment to talk further with an options counselor about her

decision. [Court's Exhibit 1 at ¶ 20].

48. At an options counseling session, an RHCC counselor talks with the woman about her feelings about her pregnancy. The purpose of the session is to let the woman know about each of the three options available to her: carrying to term and keeping the child, carrying to term and giving the child up for adoption, and abortion. Where appropriate, the woman is urged to talk about these options with supporting family members and friends. The role of the counselor in these sessions is to support the decision of the woman and to provide information that would be necessary as she acts on her decision. [Court's Exhibit 1 at ¶ 22].

49. Pre-abortion counseling at RHCC, which each woman must participate in on the day of her abortion and which

is different from options counseling, involves a discussion of the woman's decision, a review of her medical history and a description of the risks and complications of the abortion procedure. The informed consent part of the session is done with groups of four women. The counselor describes the medical procedure, reviews the risks and complications, and answers questions or addresses concerns. RHCC also provides counseling to the person or persons who accompany women for abortions. [Court's Exhibit 1 at ¶ 23].

50. Pre-abortion and options counselors are trained and supervised by RHCC's head counselor who has nine years counseling experience. [Court's Exhibit 1 at ¶ 24].

51. Telephone counselors' salaries at RHCC are between $6 and $6.30 an

hour. For options counselors, salaries begin at $6.30 an hour. [Court's Exhibit 1-A at ¶ 134].

52. RHCC counselors are not required to have a bachelor's degree. [Court's Exhibit 1-A at ¶ 135].

53. If a woman receives options counseling and pre-abortion counseling at RHCC, such counseling occurs on different days, with options counseling being available on Tuesdays and Thursdays. [Court's Exhibit 1-A at ¶ 136].

54. In 1987, RHCC performed abortions on 349 minors. Approximately 60% of these minors were accompanied by a parent. That percentage has decreased to approximately 5o%. All minors who choose not to be accompanied by a parent are required to bring a responsible adult with them to RHCC who will stay in

the building as long as the minor is there and will accompany the minor home. [Court's Exhibit 1 at ¶ 18; Court's Exhibit 1-A at 145].

55. RHCC strongly urges options counseling for all minors who have not involved their parents in the decision. [Court's Exhibit 1 at ¶ 21].

56. In general, RHCC supports and encourages parental involvement in the abortion decision where possible. [Court's Exhibit 1-A at ¶ 137].

57. If a parent accompanies a minor to RHCC for the abortion procedure, the minor reviews the risks and informed consent provision in the group session while the waiting room counselor goes over that information, including possible complications, with the parent. [Court's Exhibit 1-A at ¶ 138].

58. RHCC keeps statistics on

complications. [Court's Exhibit 1-A at ¶ 139].

59. The Medical History Form used by RHCC was being used prior to the 1988 amendments to the Act. [Court's Exhibit 1-A at ¶ 142].

60. RHCC submits quarterly reports of complications to the National Abortion Federation. [Court's Exhibit 1-A at ¶ 143].

61. Doctors at RHCC sign the individual reporting forms (Report of Induced Termination of Pregnancy) submitted to the Pennsylvania Department of Health ("PaDOH") immediately following the abortion procedure. [Court's Exhibit 1-A at ¶ 144].

62. No physician at RHCC has ceased performing abortions because their identity is listed on PaDOH pregnancy

termination forms. [Court's Exhibit 1-A at ¶ 140].

(3) Women's Health Services and Dr. Allen

63. WHS has a staff of approximately 75 people (including 8 physicians, 14 nurses and 33 counselors) and offers ongoing programs which are inclusive of approximately 2,700 client contacts a month. [Court's Exhibit 1 at ¶ 25].

64. Free pregnancy testing and counseling are available at WHS daily, Monday through Saturday. Abortions are performed Tuesdays, Fridays and Saturdays. Gynecology clinics are held on Wednesdays, Thursdays, and any other day a patient's condition dictates. Once their pregnancy is diagnosed, clients usually schedule their abortions by telephone. [Court's Exhibit 1 at ¶ 26].

65. WHS provides approximately 12,900 free pregnancy tests and 7,000 first trimester and early second trimester abortions each year. The abortion procedure at WHS costs as follows: $330 if twelve weeks or less from the last menstrual period; and $430 if thirteen to fourteen weeks from the last menstrual period; and $650 if fifteen to sixteen weeks from the last menstrual period. The fee includes the abortion procedure, laboratory testing, personal counseling, contraceptive care, pathological examination and medical supervision during the post-surgical recovery period. [Court Exhibit 1 at ¶ 27].

66. WHS does not perform abortions after 17 weeks gestation. [Court's Exhibit 1-A at ¶ 85].

67. If clients are eligible for

medical assistance, WHS takes the necessary information and seeks reimbursement from the Commonwealth. Medical assistance is available only where the abortion is necessary because of the life-threatening condition, or because the patient was a victim of rape or incest. In 1989, WHS was reimbursed for 46 such abortions. [Court's Exhibit 1 at ¶ 28].

68. Where a client receives medical assistance from the state, but is not eligible for medical assistance for an abortion, WHS nevertheless will discount the cost of the abortion. Last year, WHS accommodated 1,170 clients who were unable to pay the full amount. WHS has never turned away any client seeking an abortion merely because of inability to pay. [Court's Exhibit 1 at ¶ 29].

69. WHS's clients come primarily

from Allegheny County. In 1989, however, 909 of their abortion patients came from areas in excess of two hours travelling time (100 miles) from the clinic. [Court's Exhibit 1 at ¶ 30].

70. When a patient presents herself at the WHS clinic, she receives a pregnancy test and blood tests. [Court's Exhibit 1 at ¶ 32].

71. As to WHS, free pregnancy tests and counseling are available Monday through Saturday, but 95% of counseling services are provided on the same day of the abortion. [Court's Exhibit 1-A at ¶ 110].

72. Both Magee and WHS take a patient's history prior to performing the abortion. [Court's Exhibit 1-A at ¶ 90].

73. In Dr. Allen's private practice, a patient completes a history

form, which is a sort of health questionnaire, which is then amplified by a nurse's questions and further amplified by the physician when he sees her. [Court's Exhibit 1-A at ¶ 91].

74. At WHS, the patient completes the history form, which is gone over by a counselor, and then the physician reviews it prior to performing the abortion. [Court's Exhibit 1-A at ¶ 92].

75. All women are required to have an individual interview with a counselor on the day of their abortion. During this interview, a woman is counseled with respect to her options and her decision to have an abortion. Information regarding the risks and benefits of the abortion procedure and the patient's medical history is provided to her. In that connection, the counselor seeks to ensure that the

woman is not unduly ambivalent about her decision and that she is not being coerced. In addition, the counselor discusses future contraceptive use with the patient. [Court's Exhibit 1 at ¶ 33].

76. If the client appears ambivalent about her decision, the counselor will refer her to one of the staff therapists and the abortion will be rescheduled to give the patient more time to consider her options. On rare occasions, the clinic will refuse to perform the abortion, if convinced of the patient's continued ambivalence. [Court's Exhibit 1 at ¶ 34].

77. Options counseling is provided on the day of the procedure by WHS professional counselors who are selected on the basis of personal qualifications and maturity. [Court's Exhibit 1 at ¶ 36].

78. Extensive and intensive problem pregnancy counseling is available at WHS at no charge to clients either before or after a decision with respect to an abortion has been made, regardless of what that decision may be. Personal counseling is also available after the abortion procedure and clients are encouraged to take advantage of that service. [Court's Exhibit 1 at ¶ 37].

79. At WHS, the average counseling takes 20 minutes. [Court's Exhibit 1-A at ¶ 102].

80. In 1989, 703 of WHS's abortion patients were under the age of 18. WHS presently encourages minors to bring a parent or other adult with them. Because WHS believes that parental involvement should be encouraged, clinic counselors are instructed to offer to speak with the minor's parents, if the

minor would prefer that to making direct contact herself. When minors refuse to inform their parents under any circumstances, their wishes are currently respected. [Court's Exhibit 1 at ¶ 31].

81. Fifty percent of the minors who go to WHS are accompanied by a parent. When a parent accompanies a minor seeking an abortion, WHS first counsels the minor with respect to her options and her decision to have an abortion, and also provides her with information on future contraceptive use. The parent is then asked to join the minor, at which time the abortion procedure and possible complications are described. The counselor also answers any questions they might have. An informed consent form is then read out loud to the parent and minor while they follow along with

their own copies. Each then signs the form in the medical record. [Court's Exhibit 1 at ¶ 35; Court's Exhibit 1-A at ¶¶ 97, 101].

82. No abortion can be performed on a minor at Magee without a parent's written consent. [Court's Exhibit 1-A at ¶ 94].

83. Approximately 30% of Dr. Allen's patients seeking abortions are minors. [Court's Exhibit 1-A at ¶ 95].

84. If a parent comes with a minor for an abortion procedure at Magee, Dr. Allen will speak to the parent too. If a parent comes with a minor for an abortion procedure at WHS, a counselor speaks to the parent. [Court's Exhibit 1-A at ¶ 96].

85. At present, WHS's director of personal counseling holds a Ph.D. [Court's Exhibit 1 at ¶ 38].

86. Personal counselors at WHS are professional therapists who have at least five years of clinically supervised experience at the master's degree level or above. [Court's Exhibit 1 at ¶ 39].

87. Both paraprofessional and professional counselors at WHS are required to begin their employment with a week of classroom preparation, consisting of approximately 35 hours of medical and counseling orientation to the abortion clinic. This instruction is provided by the associate medical director, director of counseling, and director of clinical services. [Court's Exhibit 1 at ¶ 40].

88. The medical information to be presented by counselors at WHS is developed under the supervision of a physician, the WHS associate medical

director. The counseling protocols are developed and presented under the supervision of the director of counseling who holds a Ph.D. from the University of Pittsburgh. WHS also has an ongoing training module comprised of monthly in-services and quarterly individual supervision. [Court's Exhibit 1 at ¶ 41]

89. Dr. Allen always does some counseling with his patient prior to the procedure and goes over the informed consent form with them. [Court's Exhibit 1-A at ¶ 89].

90. Dr. Allen signs PaDOH reporting forms for Magee but WHS uses his signature stamp for such forms. [Court's Exhibit 1-A at ¶ 93].

91. WHS has a hot-line for women to call if they have any unusual symptoms or problems after an abortion to make

sure there is immediate treatment. [Court's Exhibit 1-A at ¶ 103].

92. WHS provides information to the National Abortion Federation and the Alan Guttmacher Institute, including information concerning complications and the frequency that WHS's patients report to them or WHS observes them. [Court's Exhibit 1-A at ¶ 105].

93. If a medical emergency resulting from an abortion performed at WHS occurs, an ambulance is called to take the person to the hospital. [Court's Exhibit 1-A at ¶ 111].

(4) Women's Suburban Clinic

94. WSC performs approximately 3,350 first trimester abortions a year. Abortions are performed Tuesdays, Wednesdays and Thursdays. [Court's Exhibit 1 at ¶ 43].

95. The fee for an abortion at WSC

is $275. At present, WSC accepts state medical assistance reimbursement for abortions for cases of rape, incest and life endangerment. Approximately 40 such claims are reimbursed by the Commonwealth annually. [Court's Exhibit 1 at ¶ 45].

96. Appointments for counseling and abortions are made through WSC telephone counselors. A positive pregnancy test is required before an abortion is scheduled. [Court's Exhibit 1 at ¶ 46].

97. The telephone counselors at WSC make appointments and receive clients but they do not counsel about pregnancy options. [Court's Exhibit 1-A at ¶ 125].

98. Depending on the patient interest and availability, appointments are made at WSC in one of the following ways:

a. If a woman requests counseling

and the abortion on the same day, the first available appointment is given. There is often a one to two week wait in obtaining an appointment. Approximately 70% of the abortion appointments are scheduled this way.

b. If a woman wants to see a counselor prior to the day of her abortion, a pre-abortion session is scheduled. Approximately 30% of the abortion appointments are scheduled this way. [Court's Exhibit 1 at ¶ 47].

99. A woman who calls WSC and expresses concern and confusion over an unwanted pregnancy is offered an opportunity to see a counselor to discuss her options. Resource information is available for options

including keeping the child, foster care and adoption. Information concerning maternity homes is also available for those women who wish to carry their pregnancy to term. [Court's Exhibit 1 at ¶ 49].

100. All counseling at WSC is provided on an individual basis by a trained counselor. All but one member of WSC's counseling staff have master's degrees. The other has a bachelor's degree with several years experience in counseling and family planning. All have backgrounds in various fields of human services. [Court's Exhibit 1 at ¶ 50].

101. It is WSC's policy that in order to counsel effectively, without becoming overstressed by the emotional demands of the job, counselors are not permitted to provide counseling for more

than 20 hours a week. [Court's Exhibit 1 at ¶ 51].

102. WSC encourages that partners and/or parents be seen by the counselor during or after the counseling session. However, all clients are first seen alone by a WSC counselor. [Court's Exhibit 1 at ¶ 52].

103. Counseling at WSC is provided in an objective, non-judgmental manner. The client's decision is reviewed and explored. The counselor also reviews the client's medical history, describes the abortion procedure, reviews birth control methods and goes over the informed consent form. Disclosure of medical risks and benefits is made as well. Also, post-abortion information, including what to do in the event of an emergency, is reviewed. [Court's Exhibit 1 at ¶ 53].

104. For women who express ambivalence over their abortion decision, the WSC counselor will further explore the issues. If the counselor feels that the woman is not sure of her decision, it is suggested that she take some time to reevaluate her choice. Additional counseling is available to assist the woman to come to a decision with which she feels comfortable. [Court's Exhibit 1 at ¶ 54].

105. Counselors at WSC start at $8.50 per hour and are all part-time employees. [Court's Exhibit 1-A at ¶ 126].

106. Of the approximately 3,350 abortions WSC performed in 1987, 410 (12.25%) were performed on minors. [Court's Exhibit 1 at ¶ 44].

107. WSC encourages minors to attend with a parent. [Court's Exhibit

1-A at ¶ 127].

108. All minors who have not informed a parent about their decision to have an abortion are asked to come to WSC for pre-counseling before the abortion appointment. This is done to give adolescents the opportunity to explore with a counselor their reasons for not involving their parents and affords them the time and opportunity to reevaluate that decision prior to the abortion. [Court's Exhibit 1 at ¶ 48].

109. If a parent comes in with a minor to WSC, the minor is first seen alone by the counselor and then the parent joins the counseling session. [Court's Exhibit 1-A at ¶ 130].

110. WSC does not perform abortions due to medical emergencies defined by the Act or otherwise. [Court's Exhibit 1-A at ¶ 128].

111. If an emergency occurs when performing an abortion at WSC, a crash cart is used to stabilize the woman and then, in all probability, the woman would be transferred to a hospital based upon the physician's or medical director's decision. [Court's Exhibit 1-A at ¶ 129].

112. WSC maintains or collects internal data regarding complications that occur during the performance of abortions. [Court's Exhibit 1-A at ¶ 133].

(5) Allentown Women's Center

113. AWC provides approximately 5,300 pregnancy tests and 4,000 first trimester abortions each year. [Court's Exhibit 1 at ¶ 56].

114. Abortions are performed at AWC three to five days a week, depending on

patient need. [Court's Exhibit 1 at ¶ 57].

115. The abortion procedure at AWC costs $280, with additional charges for services such as RhoGam shots for women more than twelve weeks pregnant, and general anesthesia. The fee includes personal counseling both before and after the abortion, the abortion procedure, laboratory testing, and medical supervision during the post-surgical period. [Court's Exhibit 1 at ¶ 58].

116. For patients who receive medical assistance from the Commonwealth, AWC's fee for abortion is $225. [Court's Exhibit 1 at ¶ 59].

117. In the case of those medical assistance patients who require an abortion because of a life-threatening disease or because they were victims of

rape or incest, AWC has received reimbursement from the state, so that no fee was charged directly to the patient. In 1987, AWC received less than $4,000 in medical assistance funds. [Court's Exhibit 1 at ¶ 60].

118. AWC's patients come primarily from an 18-county area in northern Pennsylvania encompassing the counties of Lehigh, Northampton, Carbon, Schuylkill, Luzerne, Lackawanna, Lebanon, Berks, Bucks, Pike, Chester, Lancaster, Susquehanna, Wayne, Monroe, Montgomery, Columbia and Wyoming. Many of these counties have no clinics or hospitals at which abortions are performed, AWC being the closest facility to which women can come. [Court's Exhibit 1 at ¶ 61].

119. In most cases, appointments for counseling and abortions at AWC are

made through AWC's telephone counselors. A positive pregnancy test is required before an abortion will be scheduled. When a woman calls requesting an abortion, the telephone counselor collects personal data, menstrual history and medical history. If the caller is a minor, the telephone interview is more extended to assure that the minor fully understands what she must do and what the procedure will involve. [Court's Exhibit 1 at ¶ 64].

120. When a telephone counselor makes an appointment, pre-abortion instructions are given to the woman. These instructions include what the woman must do and what she must bring with her on the day of the appointment. [Court's Exhibit 1 at ¶ 65].

121. Any woman who calls AWC and expresses concern and confusion over an

unwanted pregnancy is offered an opportunity to see a counselor to discuss her options. Resource information is available for options, including keeping the child, foster care and adoption. Information concerning prenatal care, welfare and support services is also available for those women who wish to carry their pregnancy to term. [Court's Exhibit 1 at ¶ 66].

122. A nurse practitioner or physician's assistant is available to examine all women and, where necessary, provide a pregnancy test and blood work-up. In addition, all women are required to have an individual interview with a counselor on the day their abortion is scheduled. In this interview, the abortion procedure and other alternatives are explained to the woman. [Court's Exhibit 1 at ¶ 67].

123. If the patient appears ambivalent about her decision to have an abortion, the AWC counselor will review options and suggest that the patient take more time to consider her decision before terminating the pregnancy. On occasion, the clinic has refused to permit an abortion if, after consultation, the counselor and the clinic supervisor are convinced of the woman's extreme ambivalence, coercion, or that she is otherwise overly distraught. Sometimes, but infrequently, they will refer these women to outside counselors. [Court's Exhibit 1 at ¶ 68].

124. In 1987, 563 of AWC's abortion patients were 17 or under. Of these, 3 were age 13; 32 were age 14; 64 were age 15; 178 were age 16; and 286 were age 17. [Court's Exhibit 1 at ¶ 62].

125. AWC encourages its minor patients to involve their parents in the abortion decision and to bring a parent or other supporting adult with them at the time of counseling and the procedure. Clinic counselors are routinely available to speak with a minor's parents. When a minor refuses to inform her parents under any circumstances, AWC respects those wishes. [Court's Exhibit 1 at ¶ 63].

126. When a parent does accompany a minor to the AWC clinic, a counselor will first meet privately with the minor. After assuring that the minor has reached her decision to have an abortion freely and without coercion, the counselor will give the minor the option to continue the counseling session jointly with her parent, or to be counselled separately. In either

case, the counselor will describe the procedure and possible complications as well as answer any questions she or her parent may have. The minor is then asked to sign an informed consent form. [Court's Exhibit 1 at ¶ 69].

127. When a minor chooses not to have a parent involved, AWC counselors explore and encourage the involvement of a supporting adult. Counseling of a minor who has not informed her parents is more extensive and includes a discussion of why she has chosen not to involve her parents. [Court's Exhibit 1 at ¶ 70].

128. The options counseling provided on the day of the procedure at AWC is conducted by paraprofessional staff counselors who are selected on the basis of personal qualifications. Most of the counseling staff have bachelor's

degrees. Two are presently working on master's degrees. All have backgrounds in various fields of human service. [Court's Exhibit 1 at ¶ 71].

129. All of AWC's counselors are required to begin their employment with at least a week of orientation. Instruction is provided by the Director, a nurse practitioner, the Patient Services Coordinator and other counseling staff. During the first several months of work, the new staff has frequent meetings either on an individual basis or as a group with administrative staff to reinforce correct integration of medical information and continued development of interviewing skills. [Court's Exhibit 1 at ¶ 72].

130. All medical information is developed and presented under the supervision of a physician who is

AWC's medical director. The counseling protocols are developed under the supervision of the Patient Services Coordinator. [Court's Exhibit 1 at ¶ 73].

131. There is no minimum education requirement for AWC's counselors. [Court's Exhibit 1-A at ¶ 146].

132. AWC does not accept state appropriated funds. [Court's Exhibit 1-A at ¶ 148].

133. AWC provides information to the National Abortion Federation regarding AWC's complication rate. [Court's Exhibit 1-A at ¶ 149].

134. AWC, prior to 1988, advertised in the newspapers although it does not presently advertise there. AWC does advertise in telephone directories. [Court's Exhibit 1-A at ¶ 150].

C. Other Relevant Statistical Evidence.

135. The following table represents the number of abortions performed in Pennsylvania and reported to PaDOH over the past ten years:

YEAR	NUMBER OF ABORTIONS PERFORMED
1989[20]	51,341
1988	50,786
1987	51,360
1986	51,666
1985	53,465
1984	59,258
1983	59,288
1982	60,772
1981	62,701
1980	65,777

[Court's Exhibit 1 at ¶ 76; Trial Testimony of Dr. Potrzebowski, Vol. III at 118; see also Casey I, 686 F. Supp. at 1101 (¶ 95)].

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20. The 1989 statistics provided by Dr. Potrzebowski are only provisional figures.

136. Of the 50,786 abortions performed in Pennsylvania in 1988, 47,548 (93.6%) were performed within the first three months of pregnancy. [Court's Exhibit 1 at ¶ 77]. Conversely, 3,238 (6.4%) were performed after the first three months of pregnancy.

137. Plaintiffs are unaware of any free standing abortion clinics in Pennsylvania that perform pregnancy termination procedures after the 18th week of gestation. [Court's Exhibit 1-A at ¶ 109].

138. Patients under the age of 18 accounted for 11.6%, or 5,888 of the abortions reported in Pennsylvania in 1988. [Court's Exhibit 1 at ¶ 78].

139. Of the 50,786 abortions performed in Pennsylvania and reported to PaDOH, 47,802 were performed on Pennsylvania residents. Residents of other states and territories accounted for 2,975 abortions, and residents of other countries accounted for 9. Of the 1988 abortion patients residing in Pennsylvania, 15,269 (30%) resided in Philadelphia: 7,337 (14%) resided in Allegheny County; 2,863 (6%) resided in Montgomery County; 2,270 (4%) resided in Delaware County; and 2,141 (4%) resided in Bucks County. [Court's Exhibit 1 at ¶ 79].

140. The following table represents the numbers of induced terminations of pregnancies performed on minors, as reported to PaDOH, in Pennsylvania in 1988 by age of woman:

AGE (YEARS)	NUMBER
11 or less	1
12	20
13	113
14	377
15	855
16	1,702
17	2,820

[Court's Exhibit 1 at ¶ 80].

141. During 1989, minor women received abortions at plaintiff-clinics as follows:

CLINIC	AGE GROUP	NUMBER
RHCC	14 years and under -	27
	15-17 years -	267
AWC	13 years old -	4
	14 years old -	22
	15 years old -	71
	16 years old -	160
	17 years old -	257
WSC	12 years old -	1
	13 years old -	6
	14 years old -	15
	15 years old -	27
	16 years old -	66
	17 years old -	119
PPSP	12 years old-	2
	13 years old-	14
	14 years old -	27
	15 years old -	80
	16 years old -	122
	17 years old -	189

WHS

12 years old -	2
13 years old -	11
14 years old -	33
15 years old -	117
16 years old -	226
17 years old -	314

Court's Exhibit 1-A at ¶ 82].

142. Of all abortions performed in Pennsylvania in 1988 and reported to PaDOH, 50,256 involved a dilation, evacuation, and curettage procedure. Intrauterine prostaglandin instillation was the procedure for 41. One abortion procedure was performed by a hysterotomy procedure, and none was performed by a hysterectomy. [Court's Exhibit 1 at ¶ 81].

143. According to the provisional statistical compilations of PaDOH, 391 pregnancy complications were reported in 1989. Of the 391 complications reported in 1989, 5 were caused by malignancy, 7 by endocervical polyps, 3 by rubella, 2

by hydatid moles, and 374 by other causes for which no further statistical breakdown presently exists. [Trial Testimony of Dr. Potrzebowski, Vol. III at 120].

144. The risk of death from an abortion is dependent upon numerous factors, which factors include length of gestation, the type of procedure used to perform the abortion, the medical condition of the patient, and the skill of the physician performing the abortion. [Court's Exhibit 1-A at ¶ 83].

145. From the standpoint of risks of complications and mortality, eight weeks gestation is the safest time, statistically, for the performance of an abortion. [Trial Testimony of Dr. Allen, Vol. I at 46, 71-72]. Beyond eight weeks gestation, the risk of complications (by approximately 30%) and

mortality increase (by approximately 50%) with each additional week of gestation. [Trial Testimony of Dr. Allen, Vol. I at 45; Trial Testimony of Dr. Bowes, Vol. III at 54-56].

146. An abortion is twice as safe as a tonsillectomy and 100 times safer than an appendectomy. [Trial Testimony of Dr. Allen, Vol. I at 47]. The following table represents the risk of mortality from an abortion procedure, according to data complied by the Center for Disease Control:

GESTATIONAL AGE (in weeks)	NUMBER OF DEATHS (per 100,000)
8 or less	.5
9 to 10	.8
11 to 12	1.1
13 to 15	1.5
16 to 20	7.8
over 20	3.6

[Trial Testimony of Dr. Bowes, Vol. III at 55-56].

D. The Act.

147. On March 25, 1988, Act No. 31, amending the Pennsylvania Abortion Control Act of 1982, 18 Pa. C.S.A. §§ 3201-20, was enacted. Act 31 was scheduled to take effect thirty (30) days after enactment, on April 24, 1988. [Court's Exhibit 1 at ¶ 74].

148. On November 17, 1989, Act No. 64, further amending the Pennsylvania Abortion Control Act of 1982 was enacted. Act 64 was scheduled to take effect sixty (60) days after enactment, on January 16, 1990. [Court's Exhibit 1 at ¶ 75].

(1) Definition of Medical Emergency (Section 3203)

149. Section 3203 of the Act defines the term "medical emergency" as "[t]hat condition which, on the basis of

the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function." 18 Pa. Con. Stat. Ann. §3203. The Act does not further define the terms "serious risk," "substantial and irreversible impairment," or "major bodily function."

150. This definition applies to the following provisions of the Act containing medical emergency exceptions: section 3205 (informed consent); section 3206 (parental consent or judicial by-pass); section 3209 (spousal notification); section 3210 (determination of gestational age); and

3211 (performance of abortions after 24 weeks gestation). Penalties for violation of these provisions include suspension or revocation of the physician's license or criminal conviction for a third degree felony or third degree misdemeanor.

151. The 1989 amendments to the Act did not change the definition of medical emergency despite my ruling on plaintiffs' motion for a preliminary injunction which invalidated this definition and enjoined all those sections of the Act which contained the term. See Casey I, 686 F. Supp. at 1136-37. Prior to the 1988 amendments, "medical emergency" was defined as "[t]hat condition which, on the basis of the physician's best clinical judgment, so complicates a pregnancy as to necessitate the immediate abortion of

same to avert the death of the mother or for which a 24-hour delay will create grave peril of immediate and irreversible loss of major bodily function." See 1982 Pa. Laws 476, 478, § 1.

152. According to the generally accepted definition of a medical emergency in emergency medicine, an emergency is any medical condition that requires intervention, both diagnostic and treatment, quickly. [Trial Testimony of Dr. Davidson, Vol. I at 14-15]. In emergency medicine, it is essential that doctors be flexible in their response to their patients. Every patient is different and each emergency condition presents the physician with a dynamic situation in which judgments must be made quickly and, if necessary, quickly altered or adjusted. [Trial

Testimony of Dr. Davidson, Vol. I at 14, 21-22].

153. Pennsylvania's Emergency Medical Services Act defines a medical emergency as "a combination of circumstances resulting in a need for immediate medical intervention." See 35 Pa. Con. Stat. Ann. § 6923 (Purdon 1990 Supp.).

154. The definition of medical emergency in the Act departs from the normal medical definition of an emergency and is inconsistent with that contained in Pennsylvania's Emergency Medical Services Act. [Trial Testimony of Dr. Davidson, Vol. I at 15-17; Trial Testimony of Dr. Bolognese, Vol. I at 142; Preliminary Injunction Hearing Testimony of Dr. Dratman at 61]. Defendants' expert, Dr. Bowes, agrees that the definition of medical emergency

in the Act differs from other definitions commonly used in the medical profession. [Trial Testimony of Dr. Bowes, Vol. III at 81-82].

155. No other law infringes so heavily on a physician's discretion to decide when he or she is faced with a medical emergency as the provisions of the Act. [Trial Testimony of Dr. Davidson, Vol. I at 15-16; Trial Testimony of Dr. Bowes, Vol. III at 81-82].

156. Under typical emergency conditions, the definition of "medical emergency" of the Act would cause the physician confusion regarding the proper treatment of the patient and hinder his or her ability to make a rapid response to the detriment of the health of their patient, or it would cause physicians to unknowingly violate the Act by acting in accordance with their medical training

and professional judgment rather than conforming to the requirements of the Act. [Trial Testimony of Dr. Bolognese, Vol. I at 143-44].

157. The Act's narrow definition of medical emergency may require a physician to act in ways that do not protect or restore the health of his or her patient in instances where a delay in the abortion procedure will pose a risk to the patient's health, but an immediate abortion may not be necessary to avert her death or to prevent a serious risk of the substantial and irreversible loss of a major bodily function. [Trial Testimony of Dr. Davidson, Vol I at 20-21].

158. The restrictive definition of medical emergency in the Act could exacerbate existing emergency situations. Or the definition could create emergencies because physicians

fearful of civil or criminal sanctions under the Act may delay treatment of an emergency or hesitate to act in the best interests of his or her patient. [Trial Testimony of Dr. Davidson, Vol. I at 34-35; Trial Testimony of Dr. Bolognese, Vol. I at 143-44].

159. The definition of medical emergency in the Act permits the physician to exercise his or her "good faith clinical judgment" in determining whether a medical emergency exists. However, this does not alter the fact that a "serious risk of substantial and irreversible impairment of major bodily function" must exist for a situation to constitute a medical emergency under the Act. Nor does it alter the fact that the definition of medical emergency in the Act is inconsistent with the generally accepted definition of medical emergency in the medical profession.

Further, the risk of loss of license or criminal liability hinders the physician's ability to rely upon his or her good faith clinical judgment.[21] [Trial Testimony of Davidson, Vol. I at 34-35; Trial Testimony of Dr. Bolognese, Vol I. at 143-44; Preliminary Injunction Hearing Testimony of Dr. Dratman at 63].

160. Under no other circumstances would a physician be required to delay treatment when presented with a patient with a risk, as opposed to a "serious risk," of an impairment, as opposed to a "substantial and irreversible

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21. While defendants' expert witness Dr. Bowes testified that he did not think such consequences would affect a physician's judgment since practicing medicine is already wrought with stress, he admitted that the potential criminal liability established by the Act could cause physicians to become more cautious in their practice of medicine and add stress to an already stressful profession. [Trial Testimony of Dr. Bowes, Vol. III at 76, 83].

impairment," of any bodily function, as opposed to a "major bodily function." Such a requirement is contrary to generally accepted standards of emergency medical care, and interferes with a physician's ability to act in accordance with his best medical judgment.

161. A patient's entitlement to immediate medical care, under the Act, would depend upon the individual physician's assessment of the severity of the condition and whether that physician considered the impairment to be: (1) substantial and irreversible and (2) to a major bodily function. Different interpretations of the Act could result in different patients, with similar or identical symptoms, in need of emergency medical care receiving different treatment. This difference of

opinion is amply illustrated by the testimony of Dr. Bowes and Dr. Bolognese. Dr. Bowes, an obstetrician and gynecologist, did not include the uterus or other female reproductive organs within his definition of major bodily function. Dr. Bolognese, also an obstetrician and gynecologist, on the other hand, testified that he would include such organs within this definition. [Trial Testimony of Dr. Bolognese, Vol. I at 142; Trial Testimony of Dr. Bowes, Vol. III at 34-35].

162. Plaintiffs have presented three examples of how the definition of medical emergency contained in the Act may depart from standard medical practice in emergency situations.

163. Frequently pregnant women present themselves to hospital emergency rooms complaining of vaginal bleeding,

lower abdominal pain, and progressive cervical dilation, which are the symptoms of an inevitable abortion. In a 40,000 visit a year emergency room, women arrive experiencing inevitable abortions once a week. Dr. Davidson personally treats women suffering from inevitable abortions two or three times a year. Further, this occurrence is sufficiently common to permit medical trainees at the Hospital of the Medical College of Pennsylvania to see an inevitable abortion in the emergency room anywhere between five and fifty times over the course of a three-year program. [Trial Testimony of Dr. Davidson, Vol. I at 22, 26-27].

164. It is common practice for an emergency room physician, when treating a woman with an inevitable abortion, to

use an instrument to remove products of conception, including parts of the placenta or fetal parts, to alleviate the bleeding. This would constitute a partial abortion. [Trial Testimony of Dr. Davidson, Vol. I at 23, 26-27].

165. The appropriate and safest treatment for a patient experiencing an inevitable abortion is to empty the uterus immediately by dilating the cervix and evacuating the uterus. Failure to terminate the pregnancy immediately via dilation and curettage, or some other method, could expose the patient to increased risks to her health, including shock and the need for a blood transfusion, as well as continued pain and discomfort. However, with proper treatment, an inevitable abortion is generally not life

threatening or likely to cause any permanent physical impairment. [Trial Testimony of Dr. Davidson, Vol. I at 23-25].

166. An inevitable abortion is a condition for which immediate medical treatment is required in the exercise of good medical judgment but does not fall within the Act's definition of medical emergency. There is no medical reason to delay the performance of an abortion, when a woman is suffering from an inevitable abortion. Therefore, compliance with the Act would require a departure from standard of care presently existing in medical practice, and could jeopardize the health of pregnant women. [Trial Testimony of Dr. Davidson, Vol. I at 26-28, 34-35].

167. A premature ruptured membrane is another common medical condition which could be suffered by a pregnant

woman both before and after the fetus reaches the stage of viability. Between six and ten percent of the births in the United States are premature. Of those premature births, twenty-five to thirty percent of them are preceded by a premature ruptured membrane. Ruptured membranes commonly occur in women of poorer personal health or women with poorer obstetrical care, as well as with drug users or women with poor personal hygiene. [Trial Testimony of Dr. Bolognese, Vol I. at 148].

168. When an infection occurs after a rupture, the accepted course of treatment is to terminate the pregnancy immediately. Failure to terminate the pregnancy could expose the patient to increased risks to her health, including spread of the infection throughout her body, overwhelming septic infection, shock and disseminated intravascular

coagulopathy. [Trial Testimony of Dr. Bolognese, Vol. I at 151-52].

169. For pregnancy of 24 gestational weeks or less, the likelihood of a successful outcome of the pregnancy ranges from extremely poor to impossible because of the absence of amniotic fluid which permits the development of the lungs. Under these circumstances, immediate termination of the pregnancy is usually recommended. [Trial Testimony of Dr. Bolognese, Vol. I at 149-50].

170. The standard method to terminate the pregnancy when infection occurs is a vaginal delivery which is induced by the administration of Pitocin. However, delay could cause the uterus to become infected. An infection in the uterus may hinder the physician's ability to induce labor through the use

of Pitocin. In these cases, a vaginal delivery must be utilized, which places the woman at greater risk. In some cases, the physician may have to remove the uterus. [Trial Testimony of Dr.Bolognese, Vol. I at 152-53].

171. Among the patients treated in an obstetrical practice, particularly high risk obstetrics, are pregnant women, including minors, who are experiencing complications known as preeclampsia (toxemia of pregnancy). Preeclampsia is a combination of symptoms related to an immunological disorder which tends to occur more frequently in first time pregnancies and younger patients. The recommended course of treatment is the induction of labor for a vaginal delivery. Delay could worsen maternal health and cause a loss of oxygen to the fetus. Eclampsia,

a seizure disorder caused by edema or excess fluid, and HELLP Syndrome, an adult respiratory distress syndrome caused by fluid retention in the lungs, are possible further developments of preeclampsia. While a patient with preeclampsia is at risk, there is no immediate "serious risk of substantial and irreversible impairment of [a] major bodily function." However, once the symptoms manifest themselves, there is no medical reason for delay. [Trial Testimony of Dr. Bolognese, Vol. I at 154-56; Preliminary Injunction Hearing Testimony of Dr. Dratman at 59-61].

172. An example of how the definition of medical emergency in the Act may depart from medical practices is illustrated by the following hypothetical. A 16 year-old woman is 18 weeks pregnant. She is swollen; her

blood pressure is elevated; her urine contains a considerable amount of protein; her reflexes are very brisk. She is diagnosed as having a clinical syndrome known as preeclampsia. The only treatment for this condition is to terminate the pregnancy. Under normal obstetrical practice, her condition would be considered to pose a medical emergency. However, while eclampsia could cause seizures which could, in turn, lead to a concussion or other serious medical conditions, there is no clear risk of "substantial and irreversible impairment of major bodily function." [Preliminary Injunction Hearing Testimony of Dr. Dratman at 59-61]. Therefore, this case would not fall within the definition of medical emergency contained in the Act.

173. If required to adhere to the

definition of medical emergency contained in the Act, as opposed to the less restrictive definition used by physicians in other circumstances, a physician could delay in his or her treatment, namely the performance of an abortion, of a patient with a ruptured membrane or preeclampsia. Under these circumstances, preeclampsia and a ruptured membrane would not fall within the definition of medical emergency contained in section 3203, but would be considered an emergency warranting immediate treatment by the physician. Therefore, compliance with the Act would require a departure from standard of care presently existing in medical practice, and could ultimately jeopardize the health of the pregnant woman. [Trial Testimony of Dr. Davidson, Vol. I at 26-28, 34-35].

174. While Dr. Bowes testified that he was unaware of any condition where a patient would require an immediate abortion that would not fall within the Act's definition of medical emergency, his testimony on the subject actually supports the opinions of Dr. Davidson and Dr. Bolognese. For example, he testified that a medical emergency within the meaning of the Act would exist when a woman is experiencing an inevitable abortion but only when "serious" hemorrhaging is occurring in the patient. In respect to preeclampsia, he stated that a medical emergency within the meaning of the Act would exist "in the cases in which [preeclampsia] becomes severe" and "the patient's blood pressure is very high and other complications are occurring." When discussing a ruptured membrane, he

stated that this condition only becomes a medical emergency within the meaning of the Act when the patient develops a fever and the infection reaches the fetus. [Trial Testimony of Dr. Bowes, Vol. III at 37-42]. The credible testimony of Dr. Davidson, Dr. Bolognese and Dr. Dratman establishes that, viewing the term with the ordinary meaning given to it in the profession, the Act would not consider any of the three aforementioned conditions an emergency until much later in the progression of the seriousness of the condition.

(2) Informed Consent and Twenty-Four Hour Waiting Period (Section 3205)

175. Section 3205(a) of the Act, as amended, reads, in pertinent part, as follows:

Except in cases of a medical emergency, consent to an abortion is voluntary and informed if and only if:

(1) At least 24 hours prior to the abortion, the physician who is to perform the abortion or the referring physician has orally informed the woman of:

(i) The nature of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision of whether or not to undergo the abortion.

(ii) The probable gestational age of the unborn child at the time the abortion is to be performed.

(iii) The medical risks associated with carrying her child to term.

(2) At least 24 hours prior to the abortion, the physician who is to perform the abortion or the referring physician, or a qualified physician assistant, health care practitioner, technician, social worker to whom the responsibility has been delegated by either physician, has informed the pregnant woman that:

(i) The department[22] publishes printed materials which describe the unborn child and list agencies which offer alternatives to abortion and that she has a right to review the printed materials and that a copy will be provided to her free of charge if she chooses to review it.

(ii) Medical Assistance benefits may be available for prenatal care, childbirth and neonatal care, and that more detailed information on the availability of such assistance is contained in the printed materials published by the department.

(iii) The father of the unborn child is liable to assist in the support of her child, even in instances where he has offered to pay for the abortion. In the case of rape, this information may be omitted.

(3) A copy of the printed materials has been provided to the pregnant woman if she chooses to view these materials.

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22. The "department" is defined by the Act as "[t]he Department of Health of the Commonwealth of Pennsylvania." See 18 Pa. Cons. Stat. Ann. § 3203.

(4) The pregnant woman certifies in writing, prior to the abortion, that the information required to be provided under paragraphs (1), (2) and (3) has been provided.

18 Pa. Con. Stat. Ann. § 3205(a).

176. The 1989 amendments substantially alter the earlier 1988 amendments to subsections (a) and (c) of section 3205. See 1988 Pa. Laws 262, 263-65, § 4. In Act 64, the legislature essentially reenacted most aspects of the 1982 version of the Act found unconstitutional in prior litigation. For example, the 1982 version of section 3205 required a 24-hour waiting period, required a doctor only to advise the woman of (1) the nature and risks of the proposed procedure, (2) the gestational age of the unborn child, and (3) the medical risks associated with carrying the child to term, and required someone to advise the woman of the availability

of (1) medical assistance benefits, (2) a list of agencies which offer alternatives to abortion, (3) printed materials describing the fetus at various different stages, and (4) paternal liability to assist in the support of her child. See 1982 Pa. Laws 476, 479-81, § 1.

177. Section 3208(a) of the Act, as amended, requires PaDOH to prepare, publish and update on an annual basis easily comprehensible printed materials which would comply with the informed consent requirements of section 3205(a). The printed information must be prepared in English, Spanish and Vietnamese. See 18 Pa. Con. Stat. Ann. §3208(a). All materials must be printed in typeface large enough to be clearly legible, 18 Pa. Con. Stat. Ann. § 3208(b), and available at no cost from

PaDOH to any person, facility or hospital. 18 Pa. Con. Stat. Ann. § 3208(c).

178. The 1989 version of section 3208 is virtually identical to the version of this section as it existed in 1988. However, Act 64 eliminated the requirement that the materials concerning the availability of social service agencies contain the following statement:

> There are many public and private agencies willing and able to help you to carry your child to term, and to assist you and your child after your child is born, whether you choose to keep your child or to place her or him for adoption. The Commonwealth of Pennsylvania strongly urges you to contact them before making a final decision about abortion.

See 1988 Pa. Laws 262, 268-69, § 4. The earlier version of section 3208 is similar to the existing version to the extent that it requires the preparation

of "[g]eographically indexed materials designed to inform the woman" of agencies available that provide alternatives to abortion and "[m]aterials designed to inform the woman of the probable anatomical and physiological characteristics of the child at two-week gestational increments." See 1982 Pa. Laws 476, 483-84, § 1.

179. If all provisions of section 3205 were to go into effect, defendants intend to require the use of a notice form prepared by PaDOH by all abortion providers during the informed consent process. The notice reads as follows:

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

NOTICES REQUIRED BY ABORTION CONTROL ACT

JULY, 1990

1. It is generally unlawful for any individual to coerce a woman to undergo [an] abortion.

2. Any physician who performs an abortion upon a woman without according her a private medical consultation may be liable to her for damages in a civil action at law.

3. The father of a child is liable to assist in the support of that child, even in instances where the father has offered to pay for an abortion. The availability of support payments will depend, in part, on the father's income. You may wish to consult a lawyer regarding the availability of support payments.

4. The law permits adoptive parents to pay costs of prenatal care, childbirth and neonatal care.

[Trial Testimony of Dr. Patrozebowski, Vol. III at 112-13, 136-37; Defendants' Exhibit 51].

180. If all provisions of section 3205 were to go into effect, defendants intend to require the use of a form which reads as follows:

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF HEALTH

MEDICAL ASSISTANCE BENEFITS FOR

PRENATAL CARE, CHILDBIRTH AND

NEONATAL CARE

JULY, 1990

You may or may not qualify for medical assistance benefits, depending on your income. For persons who qualify, the Medical Assistance Program will pay for doctor, clinic, hospital, and other related medical expenses so you can receive prenatal care, delivery services, and care for your newborn baby. You can apply for Medical Assistance benefits at your local County Assistance Office.

Under the Healthy New Beginnings Program you may be eligible for Medical Assistance because you are pregnant. A pregnant woman is allowed to have more income to qualify for this benefit and may receive prenatal care from certain providers while the formal application for assistance is being processed.

Your County Assistance Office can tell you which providers participate in the Medical

> Assistance Program and can answer your questions about other available benefits. County Assistance Offices are listed [on the following pages] for your information. The attached pamphlets on Medical Assistance and Healthy Beginnings also may be of assistance to you.

[Trial Testimony of Dr. Potrzebowski, Vol. III at 112, 136-37; Defendants' Exhibit 50].

181. In anticipation of the possibility that section 3205 will be permitted to go into effect, a "Directory of Social Service Organizations" to be provided to women seeking an abortion was prepared by PaDOH. For each county in Pennsylvania, the Directory provides a list of agencies that "provide a variety of services which may assist a woman through pregnancy, upon childbirth, and while the child is dependent." Examples of services provided by these agencies are "counseling, pregnancy testing,

medical care, legal and financial assistance, transportation, childbirth instruction, housing, job placement, continuing education and adoption information." [Trial Testimony of Dr. Potrzebowski, Vol. III at 111; Defendants' Exhibit 49 at 1].

182. The PaDOH-created-list of social service organizations does not include, particularly for Monroe County and Allegheny County, some agencies that provide services to pregnant women. The list also includes crisis pregnancy centers and other organizations which provide women with misinformation and inflammatory literature which increases pre-abortion anxiety. [Trial Testimony of Ms. Roselle, Vol. II at 87-89, 91-92, 112; Trial Testimony of Ms. Dillon, Vol. III at 159-60].

183. Nothing in the Act prohibits abortion providers that would be

required to supply this list to abortion patients from recommending a patient avoid a particular agency on the list. Nor does anything in the Act prohibit abortion providers from recommending a particular agency, whether on the list or not, to a patient in light of that patient's individual needs.

184. Nothing in the record suggests that the Directory could not be supplemented by PaDOH to include those agencies omitted from the list.

185. The informed consent requirements of the Act represent a substantial departure from the ordinary medical requirements of informed consent. [Trial Testimony of Dr. Bowes, Vol. III at 71].

186. "Informed consent" as used in section 3205 has a medically and legally distinct meaning which is different than

simple "consent." [Trial Testimony of Dr. Grodin, Vol. I at 96-97].

187. As a general rule, informed consent requires communications between the doctor or counselor and patient to assure that the patient has made a treatment choice based upon knowledge of his or her condition, the benefits and risks of a particular treatment and its alternatives. In order to be informed, consent must be made voluntarily and competently. [Trial Testimony of Dr. Grodin, Vol. I at 96-97; Trial Testimony of Dr. Allen, Vol. I at 40-41].

188. Although the informed consent dialogue may be brief (the length of the dialogue will depend in a great part upon the complexity of the procedure contemplated), personal contact between the patient and the person rendering the informed consent is essential. The

physician's or counselor's observation of the person's demeanor and reactions to medical information provided is essential to permit the physician or counselor to determine whether the patient is competent to give informed consent and whether the patient fully understood the information imparted during the dialogue. Further, personal contact is necessary to determine whether the patient is under duress from extrinsic sources while providing informed consent. [Trial Testimony of Dr. Allen, Vol. I at 41; Trial Testimony of Dr. Grodin, Vol. I at 99-105]. Even defendants' expert witness testified that telephone informed consent could only be justified, if subsequent face-to-face contact occurs. [Trial Testimony of Dr. Bowes, Vol. III at 69].

189. A patient's informed consent

cannot be obtained through the use of a tape recorded message or printed materials. [Trial Testimony of Dr. Allen, Vol. I at 42; Trial Testimony of Dr. Grodin, Vol. I at 104].

a. **The Twenty-Four Hour Waiting Period.**

190. ACOG has taken an official position in opposition to a mandatory 24-hour waiting period. [Trial Testimony of Dr. Allen, Vol. I at 47].

191. A very small percentage of women are ambivalent concerning whether to have an abortion when they come to a clinic. Arrangements for special counseling sessions are made for women demonstrating any ambivalence about her decision. [Trial Testimony of Dr. Allen, Vol. at 44-45; Trial Testimony of Ms. Roselle, Vol. II at 77].

192. If a patient is ambivalent about having an abortion and decides to

postpone the procedure to have additional counseling, that will cause a delay in the performance of the abortion. [Court's Exhibit 1-A at ¶ 98].

193. If it were to go into effect, the 24-hour waiting period of the Act will force every women seeking an abortion in Pennsylvania to make a minimum of two visits to an abortion provider. [Trial Testimony of Ms. Roselle, Vol. II at 80-81].

194. Two trips to the abortion provider would subject many women to the harassment and hostility of anti-abortion protestors demonstrating outside a clinic, such as WHS, on two separate occasions. [Trial Testimony of Dr. Allen, Vol. I at 43].

195. Because most of plaintiff-clinics and plaintiff-physicians do not perform abortions on a daily basis, the

mandatory 24-hour waiting period will result in delays far in excess of 24 hours. For the majority of women in Pennsylvania, delays will range from 48 hours to two weeks. [Trial Testimony of Ms. Roselle, Vol. II at 81-82, 106].

196. In 1988, 58% of the women obtaining abortions in Pennsylvania resided in only five of the Commonwealth's counties. Women who live in any of the other 62 counties must travel for at least one hour, and sometimes longer than three hours, to obtain an abortion from the nearest provider. [Trial Testimony of Ms. Roselle, Vol. II at 80; Verification of Ms. Roselle at ¶ 9; Verification of Ms. Stengle at ¶ 10].

197. The mandatory 24-hour waiting period would force women to double their travel time or stay overnight at a

location near the abortion facility. This will necessarily add either the costs of transportation or overnight lodging or both to the overall cost of her abortion. Additionally, many women may lose additional wages or other compensation as a result of the mandatory 24-hour delay, if forced to miss work on two separate occasions. Two trips to the abortion provider may cause the women to incur additional expenses for food and child care.

198. The costs incident to obtaining an abortion, excluding the actual cost of the procedure itself, will be greater if the 24-hour waiting period were to go into effect.

199. The mandatory 24-hour waiting period will be particularly burdensome to those women who have the least financial resources, such as the poor

and the young, those women that travel long distances, such as women living in rural areas, and those women that have difficulty explaining their whereabouts, such as battered women, school age women, and working women without sick leave.

200. In some cases, the delays caused by the 24-hour waiting period will push patients into the second trimester of their pregnancy substantially increasing the cost of the procedure itself and making the procedure more dangerous medically.

201. A delay of 24 hours will have a negative impact on both the physical and psychological health of some patients, as well as increase the risk of complications. [Trial Testimony of Dr. Allen, Vol. I at 88; Trial Testimony of Dr. Walker, Vol. II at 42-43].

202. While an abortion is still substantially safer than carrying a pregnancy to term, after the eighth week of the pregnancy, delay in the performance of the abortion increases the risk of death to the woman. [Trial Testimony of Dr. Allen, Vol. I at 45; Trial Testimony of Dr. Bowes, Vol. III at 54-56]. A substantial increase in the risk of death from an abortion procedure occurs when the pregnancy moves from the earlier stages of the second trimester to the middle portion of the second trimester (16 to 20 weeks of gestation). [Trial Testimony of Dr. Bowes, Vol. III at 56].

203. A mandatory 24-hour waiting period between the receipt of informed consent information and the performance of the abortion serves no legitimate medical interest. If a physician has

concluded that any other type of obstetrical or gynecological procedure is medically necessary and has obtained the informed consent of the patient, there is simply no medical reason to delay performance of the procedure any longer. [Trial Testimony of Dr. Allen, Vol. I at 43; Trial Testimony of Dr. Grodin, Vol. I at 118-19; Trial Testimony of Dr. Bolognese, Vol. I at 145-46].

b. **Physician-Only Disclosure Requirements.**

204. Prior to performing an abortion, trained counselors at plaintiff-clinics or plaintiff-physicians provide a patient with options counseling and obtain her informed consent to the procedure. [Trial Testimony of Dr. Allen, Vol. I at 44, 51; Trial Testimony of Ms. Roselle, Vol. II at 77-80, 113-15; Preliminary

Injunction Hearing Testimony of Ms. Stengle at 26-27; see also Findings of Fact at ¶¶ 26-27, 50, 86-88, 100-01, 128-30].

205. ACOG and the American Public Health Association have taken an official position in favor of the use of trained, qualified counselors to provide informed consent information concerning abortions. [Trial Testimony of Dr. Allen, Vol. I at 52].

206. In the last twenty years, the field of medicine has broadened and increased in complexity causing an increase in medical specialization. Accordingly, the importance of mid-level professionals to the provision of excellent, low-cost and personalized health care has grown correspondingly. [Trial Testimony of Dr. Allen, Vol. I at 52].

207. In the field of obstetrics and gynecology, a significant portion of patient care is routine, non-emergent and can be provided as effectively by trained counselors as by licensed physicians. [Trial Testimony of Dr. Allen, Vol. I at 52-53]. This is particularly true with respect to the performance of abortions.

208. Trained counselors, such as those employed or utilized on a volunteer basis by plaintiff-clinics and plaintiff-physicians, are fully capable, by virtue of their training and experience, to provide information to patients, to discuss the alternatives to abortion with the patient, and to secure the patient's informed consent to the abortion procedure. [Trial Testimony of Dr. Allen, Vol. I at 5I; Trial Testimony of Ms. Roselle, Vol. II at 78-79;

Preliminary Injunction Hearing Testimony of Ms. Stengle at 27].

209. None of the plaintiffs have physicians who perform abortions without the physician talking to the patient before the abortion procedure. [Court's Exhibit 1-A at ¶ 88].

210. Requiring physicians to give information personally will leave the physician less time to provide the medical services which he or she, as a licensed physician, can provide. [Trial Testimony of Dr. Allen, Vol. I at 51].

211. In many instances, trained counselors, who are women, are more understanding than physicians and have more time to spend with patients. Further, it is more economical for the plaintiff-clinics to utilize trained counselors to provide options counseling and informed consent information to

patients seeking an abortion. If the physician-only disclosure requirements become law, the added costs incurred by abortion providers will be imposed upon the women seeking abortions. [Trial Testimony of Dr. Allen, Vol. II at 51].

212. The requirement of section 3205 that physicians personally provide information necessary for informed consent will require extensive changes in the operating schedules of plaintiff-clinics and plaintiff-physicians. Physicians' schedules will need to be expanded to include additional medical consultation and counseling sessions which would be required by the Act[23] or additional physicians will have to be hired to provide these additional services. It will be difficult to find

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23. This would be further complicated if the 24-hour waiting period were also to go into effect.

available physicians to provide these additional services, because of the doctors' already busy schedules. [Trial Testimony of Dr. Allen, Vol. I at 50-51]. WHS has found it more difficult to maintain an adequate supply of physicians since the amendments to the Act. [Trial Testimony of Dr. Allen, Vol. I at 87].

213. The state's interest in ensuring that a woman's consent to an abortion procedure is informed and unpressured is in no way furthered by mandating the identity of the person that must obtain the informed consent. The state's interest is satisfied when a woman gives her informed consent to the procedure and receives any necessary counseling from a trained, qualified person, such as the counselors utilized by plaintiff-clinics.

c. Content-Based Informed Consent.

214. Content based informed consent is the supply of specific information to all patients regardless of the specific circumstances and needs of each individual patient. Content-based informed consent is contrary to the standard medical practice that informed consent be specifically tailored to the needs of the specific patient. [Trial Testimony of Dr. Grodin, Vol. I at 101-02, 107].

215. Medical practice requires that the informed consent dialogue between physician or counselor and patient be specifically tailored to the needs of the patient -- rather than a "reasonable patient." [Trial Testimony of Dr. Grodin, Vol. I at 107].

216. The role of the physician or counselor during the informed consent

dialogue is <u>not</u> to attempt to sway the patient's decision in one way or another. [Trial Testimony of Dr. Allen; Trial Testimony of Dr. Grodin; Trial Testimony of Dr. Bolognese; Trial Testimony of Dr. Rue; Trial Testimony of Dr. Bowes]. Options counseling is separate and distinct from informed consent. [Trial Testimony of Dr. Grodin, Vol. I at 102].

217. Section 3205(d) may actively discourage the free flow of information during the informed consent dialogue by relieving any physician "who complies with the provisions" of section 3205 from civil liability for failure to obtain informed consent. This may provide some physicians with an incentive to limit their informed consent dialogue to the four corners of section 3205 in an effort to avoid civil

liability. [Trial Testimony of Dr. Allen, Vol. I at 59-60; Trial Testimony of Dr. Grodin, Vol. I at 117-118].

218. For many women, the medical information required by section 3205 is over inclusive. For example, the Act requires a disclosure of medical risks of carrying a pregnancy to term. If a woman has decided that abortion is in her best interests, no legitimate purpose is served by informing her of maternal mortality statistics or that many women require caesarian sections at the time of delivery. [Trial Testimony of Dr. Allen, Vol. I at 55; Trial Testimony of Dr. Grodin, Vol. I at 105-06, 108-09]. Similarly, a physician would not advise a woman who has decided to carry her pregnancy to term of the risks associated with an abortion procedure. [Trial Testimony of

Dr. Allen, Vol. I at 54].

219. Prior to the scheduling of an appointment with an abortion provider, most women have already decided that an abortion is in their best interest. [Trial Testimony of Ms. Roselle, Vol. II at 109; Trial Testimony of Dr. Allen, Vol. I at 43-44]. For many women, the decision to have an abortion is a decision which they reach only after a good deal of careful thought, consultation with a family member or other trusted individual, or a medical provider. [Trial Testimony of Ms. Roselle].

220. In some cases, merely offering a woman the opportunity to read materials and examine pictures designed to inform her of the probable anatomical and physiological characteristics of the fetus at two week gestational increments

and of the possibility of the unborn child's survival, as well as a state created list of agencies that will assist her in carrying her pregnancy to term, will create undesirable and unnecessary anxiety, anguish and fear. [Trial Testimony of Dr. Grodin, Vol. I at 109-10; Trial Testimony of Ms. Roselle, Vol. II at 91-92, 112].

221. The mandated information required by sections 3205 and 3208 will create the impression in women that the Commonwealth disapproves of the woman's decision. The information and material required by these sections is an attempt by the Commonwealth to alter a woman's decision after she has determined that an abortion is in her best interest.

222. Once the decision to terminate the pregnancy is made by a woman, requiring physicians or counselors to

provide the information required by section 3205 and to offer exposure of the literature required by section 3208 will undermine the physician's or counselor's ability to counsel a patient according to her individual needs and will force the physician or counselor to act in a manner inconsistent with their professional judgment and training. [Trial Testimony of Dr. Grodin, Vol. I at 109-10; Trial Testimony of Ms. Roselle, Vol. II at 84].

223. Informing women of the availability of medical assistance benefits or paternal support for the child has no legitimate medical justification. Such information may mislead or confuse the patient, and, in the vast majority of the cases, is plainly inappropriate given the circumstances of the individual

patient. [Trial Testimony of Dr. Allen, Vol. I at 56; Trial Testimony of Dr. Grodin, Vol. I at 110-11; Trial Testimony of Ms. Roselle, Vol. II at 83-85, 90].

224. The circumstances under which medical assistance benefits or child support payments may, in reality, be available to a patient are well beyond the ordinary expertise of physicians or counselors. Advising a patient of the general availability of such benefits or payments may cause a woman to rely upon those statements and elect against an abortion only to later discover that the benefits or payments were unavailable or insufficient. [Trial Testimony of Dr. Allen, Vol. I at 56; Trial Testimony of Dr. Grodin, Vol. I at 110-11; Trial Testimony of Ms. Roselle, Vol. II

at 90; Trial Testimony of Ms. Dillon, Vol. III at 154-55].

225. The requirements that a woman be advised that medical assistance benefits or child support payments may be available, as well as some of the other information required to be offered by section 3205, are poorly veiled attempts by the Commonwealth to disguise elements of discouragement of the abortion decision.

226. The requirement that a specific body of information be given in all cases, regardless of the individual needs of the patient, intrudes upon the discretion of the physician and the woman's decision-making process. [Trial testimony of Dr. Grodin, Vol. I at 99-102].

227. Section 3205's imposition of criminal penalties[24] upon doctors or counselors is a significant departure from existing informed consent law. In no other instance does an informed consent regulation provide for criminal penalties. [Trial Testimony of Dr. Allen, Vol. I at 61].

228. Fear of criminal sanctions by counselors or doctors will cause abortion providers to apply section 3205 with extreme caution. Some doctors may discontinue performing abortion procedures. [Trial testimony of Dr. Davidson, Vol. I at 34-35; Trial Testimony of Dr. Bolognese, Vol. I at 143-44].

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[24] See 18 Pa. Con. Stat. Ann. §3205(c).

(3) Parental Consent (Section 3206)

229. Section 3206 of the Act, as amended by Act 31, provides, in pertinent part, as follows:

> Except in a medical emergency, or except as provided in this section, if a pregnant woman is less than 18 years of age and not emancipated, or if she has been adjudged an incompetent . . ., a physician shall not perform an abortion upon her unless, in the case of a woman who is less than 18 years of age, he first obtains the informed consent both of the pregnant woman and of one of her parents; or, in the case of a woman who is incompetent, he first obtains the informed consent of her guardian.

See 18 Pa. Con. Stat. Ann. § 3206(a) (emphasis added).

230. This section of the Act was not altered by the 1989 amendments to the Act. However, this section is distinct from the version that existed in 1982 inasmuch as the earlier version only required the "consent" of the pregnant woman and one of her parents--as opposed to the "informed consent" of

both individuals. See 1982 Pa. Laws 476, 481-83, § 1.

231. Inasmuch as this section of the Act requires the "informed consent" of the parent and the pregnant woman, my earlier findings pertaining to informed consent apply with equal force to this section. Therefore, they shall be incorporated by reference herein.

232. The Act does not separately define "informed" parental consent. The Act does not explicitly state that the parent must visit the clinic personally in order to give his or her informed parental consent.

233. ACOG has taken a position against forced parental notification by minors. [Trial Testimony of Dr. Allen, Vol. I at 65].

234. Clinics in Pennsylvania that offer abortion counseling services and

abortion services encourage parental involvement in the minor's decision to have an abortion whenever possible. [Verification of Ms. Roselle at ¶¶ 10, 20; Preliminary Injunction Hearing Testimony of Ms. Stengle at 28; Verification of Ms. Stengle at ¶¶ 12, 19; see also Findings of Fact at ¶¶ 29, 54-57, 80-81, 102, 106-09, 124-27].

235. There can be delays in performing an abortion on a minor who chooses to wait for her parent to be able to come to the clinic, which delay can exceed two weeks. [Court's Exhibit 1-A at ¶ 100].

236. Most minors come to a clinic in the company of an adult, even if not a parent. [Trial Testimony of Dr. Allen, Vol. I at 64].

237. Approximately 54% of AWC's minor patients have parental consent for

abortions. In all cases, AWC requires that some adult is available to care for the minor patient. [Preliminary Injunction Hearing Testimony of Ms. Stengle at 28-29].

238. Under Act 31, and in accordance with standard medical principles of informed consent, the plaintiff-clinics intend to require in-person consultation with the parent to assure the parent's consent is informed. Plaintiff-clinics consider it necessary to require in-person parental informed consent to avoid the heightened risk of criminal and civil liabilities. [Preliminary Injunction Hearing Testimony of Ms. Roselle at 11; Preliminary Injunction Hearing Testimony of Ms. Stengle at 30-31; Verification of Ms. Roselle at ¶ 21; Verification of Ms. Stengle at ¶ 25].

239. The plaintiff-clinics are unwilling to secure parental informed consent over the telephone, or by any means other than an in-person visit to the clinic. [Trial Testimony of Ms. Roselle, Vol. II at 81; Preliminary Injunction Hearing Testimony of Ms. Roselle at 10; Preliminary Injunction Hearing Testimony of Ms. Stengle; Verification of Ms. Roselle at ¶ 21].

240. An in-person visit by a parent for informed consent counseling may cause delays of several days or possibly weeks, even in cases where the parent is prepared to consent. [Verification of Ms. Stengle at ¶¶ 24, 26, 28; Verification of Ms. Roselle at ¶ 24].

241. Delays in obtaining parental consent could be both dangerous and prohibitive since a substantial number of minors decide to have an abortion

much later in their pregnancy. [Trial Testimony of Dr. Allen, Vol. I at 63; Preliminary Injunction Hearing Testimony of Ms. Roselle at 14; Verification of Ms. Roselle at ¶ 24; Verification of Ms. Stengle at ¶ 28].

242. Adolescents as a group are generally more reluctant to initiate contact with an unfamiliar group or organization. For this reason, a pregnant minor may delay the initial step of contacting the clinic until further into their pregnancies. [Verification of Ms. Roselle at ¶ 27; Verification of Ms. Stengle at ¶ 33].

243. Adolescents as a group tend to deny their pregnancies out of guilt and postpone making any decisions as to what course of action is in their best interests. [Trial Testimony of Dr. Allen, Vol. I at 63; Verification of Ms.

Stengle at ¶ 33].

244. Many adolescents are unaware of their pregnancy for weeks or months because of ignorance about their menstrual cycles, pregnancy and their own irregular menstrual cycles. [Trial Testimony of Dr. Allen at 63].

245. Further delays can arise from a minor's fear and hesitation in divulging to her parents: first, she has been sexually active; second, that she is pregnant, and third, that she wishes to have an abortion. Because of the disruption and trauma associated with these disclosures, a minor will delay telling her parents that she is pregnant for days or even weeks. [Preliminary Injunction Hearing Testimony of Ms. Roselle at 14; Preliminary Injunction Hearing Testimony of Ms. Stengle at 29; Verification of Ms. Stengle at ¶ 30].

246. The clinics often find themselves having to expedite a minor's testing, counseling and procedure because the minor has delayed going to the clinic until she is near or into the second trimester of her pregnancy. [Trial Testimony of Dr. Allen, Vol. I at 63; Trial Testimony of Ms. Roselle; Preliminary Injunction Hearing Testimony of Ms. Roselle at 15].

247. The additional costs, burdens and delays incurred by minors and her parents, if the parent is required to make an in-person visit to the facility, could be extremely costly and burdensome.

248. More second trimester abortions are performed on minors in the United States than any other age group. [Verification of Ms. Stengle at ¶ 33]. Late abortions, particularly second trimester abortions, pose a greater risk

to the woman's health. [Trial Testimony of Dr. Allen, Vol. I at 46-47; Trial Testimony of Dr. Bowes, Vol. III at 55-58; Preliminary Injunction Hearing Testimony of Ms. Stengle at 37; Verification of Ms. Stengle at ¶ 34]. Because teenagers have never experienced a prior dilation of the cervix, later abortions can be an especially dangerous procedure for them. [Preliminary Injunction Hearing Testimony of Ms. Stengle at 37].

249. Many minors have great difficulty tolerating scheduling difficulties and delay. They tend to postpone the abortion decision because of fear and anxiety. Thus, once the decision has been made, they are likely to react negatively to scheduling delay and obstacles in obtaining an abortion. Some may lie about their age to attempt

to avoid the requirements of section 3206; others may decide to carry their pregnancy to term; and some may resort to self-abortion. [Preliminary Injunction Hearing Testimony of Ms. Stengle at 37-38].

250. In some cases, where parents are prepared to consent, he or she will be unable to come to the clinic for several days for the necessary counseling because of work schedules, family obligations, travel distance, or other commitments. [Verification of Ms. Stengle at ¶ 26; Verification of Ms. Roselle at ¶ 21]. Still in other cases, a parent may refuse to accompany their daughter to the facility even though he or she has agreed to consent to the daughter's abortion. [Trial Testimony of Ms. Roselle, Vol. II at 92-93].

251. Implementation of parental

informed consent requirements of the Act will create scheduling and administrative difficulties for plaintiff-clinics and alter their current practices and procedures drastically. Counseling sessions will have to be scheduled at times and on days not presently within their staffing capabilities to accommodate the schedules of parents of minor patients. [Verification of Ms. Roselle at ¶¶ 22-23; Verification of Ms. Stengle at ¶¶ 27].

252. If the parental consent provision of the Act goes into effect, PPSP will counsel parents who attend with their minor child at the same time they counsel the minor. [Court's Exhibit 1-A at ¶ 118].

253. If the parental consent provision of the Act goes into effect,

parents may receive counseling sessions at any of PPSP's clinics. [Court's Exhibit 1-A at ¶ 119].

254. The requirement of parental informed consent for minor women seeking abortions adds significant expense and delay to the expense and delay already existing in the Act. Taken together, the provisions of the Act, as applied to minors, will create layers of obstacles which could unduly burden a minor woman's ability to get an abortion. [Trial Testimony of Ms. Roselle, Vol. II at 81-82].

255. The additional financial cost of travel, lost wages and child care expenses incurred by minors and their parents because of the parental informed consent requirements of the Act would unduly burden a minor woman's ability to get an abortion. In some cases, the

provisions may act in such a way as to deprive her of her right to have an abortion. [Preliminary Injunction Hearing Testimony of Ms. Roselle at 14-15; Preliminary Injunction Hearing Testimony of Ms. Stengle at 35; Verification of Ms. Roselle at ¶ 25].

256. In order to avoid the risk of criminal or civil penalties, the plaintiff-clinics and plaintiff-physicians will be extremely conservative as to their requirements for proof of age and parenthood. [Preliminary Injunction Hearing Testimony of Ms. Stengle at 31; Preliminary Injunction Hearing Testimony of Ms. Roselle at 10; Verification of Ms. Stengle at ¶ 31; Verification of Ms. Roselle at ¶ 26].

257. On many occasions, members of the public enter plaintiff-clinics

posing as clients or pregnant women seeking information about abortion in order to scrutinize the procedures and controls in effect at the clinic. [Preliminary Injunction Hearing Testimony of Ms. Roselle; Preliminary Injunction Hearing Testimony of Ms. Stengle].

258. Plaintiff-clinics reasonably fear that members of anti-abortion groups will send minors to the clinic posing as patients to test the clinic's compliance with section 3206. [Preliminary Injunction Hearing Testimony of Ms. Roselle].

259. All of the clinics anticipate increased expenses resulting from the parental consent provisions of section 3206. [Preliminary Injunction Hearing Testimony of Ms. Roselle at 14; Verification of Ms. Stengle at ¶ 32].

260. Pennsylvania law governing consent for medical or health services on minors provides as follows:

> Any minor who is eighteen years of age or older, or has graduated from high school, or has married or has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.

35 Pa. Con. Stat. Ann. § 10101 (Purdon 1977). Further, a minor parent may give effective consent to medical, dental or health services for his or her child. See 35 Pa. Con. Stat. Ann. § 10102.

261. Pennsylvania law governing consent for medical or health service on pregnant minors provides as follows:

> Any minor may give effective consent for medical and health services to determine the presence of or to treat pregnancy, and venereal disease . . . .

35 Pa. Con. Stat. Ann. § 10103.

262. Finally, 35 Pa. Con. Stat. Ann. § 10104 states:

> Medical, dental and health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the physician's judgment, an attempt to secure consent would result in delay of treatment which would increase the risk of the minor's life or health.

263. Section 3206(b), regarding "Unavailability of parent or guardian," provides:

> If both parents have died or are otherwise unavailable to the physician within a reasonable time and in a reasonable manner, consent of the pregnant woman's guardian or guardians shall be sufficient. If the pregnant woman's parents are divorced, consent of the parent having custody shall be sufficient. If neither any parent nor a

> legal guardian is available to the physician within a reasonable time and in a reasonable manner, consent of any adult person standing in loco parentis shall be sufficient.

18 Pa. Con. Stat. Ann. § 3206(b).

264. In part because of the failure to define the terms "reasonable time," "reasonable manner," and "person standing in loco parentis," the plaintiff-clinics will likely take a conservative approach in applying section 3206(b).

265. Many of the plaintiff-clinic's patients are minors who live with non-parents, such as aunts, grandmothers or siblings. Often the arrangement is an informal one rather than a legal guardianship, with natural parents living in another city or perhaps having abandoned the minor. The plaintiff-clinics intend to be wary of

permitting the adult "caretaker" to consent to the minor's abortion for fear of criminal or civil sanctions if officials believe that the parents could have been available in a reasonable time and manner. [Preliminary Injunction Hearing Testimony of Ms. Stengle at 32-33].

266. The provisions of section 3206 relating to the judicial by-pass procedure are self-executing on their face. There was been no testimony at the trial concerning whether the various Courts of Common Pleas in Pennsylvania were adequately prepared to implement the judicial by-pass procedures and protect the confidentiality of minors availing themselves of these procedures.

(4) Spousal Notification (Section 3209)

267. Pertinent portions of section 3209 read as follows:

(a) **Spousal notice required.**--In order to further the Commonwealth's interest in promoting the integrity of the marital relationship and to protect a spouse's interests in having children within marriage and in protecting the prenatal life of that spouse's child, no physician shall perform an abortion on a married woman, except as provided in subsections (b) and (c), unless he or she has received a signed statement, which need not be notarized, from the woman upon whom the abortion is to be performed, that she has notified her spouse that she is about to undergo an abortion. The statement shall bear a notice that any false statement made therein is punishable by law.

(b) **Exceptions.**-- The statement certifying that the notice required by subsection (a) has been given need not be furnished where the woman provides the physician a signed statement certifying at least one of the following:

(1) Her spouse is not the father of the child.

(2) Her spouse, after diligent effort, could not be located.

(3) The pregnancy is a result of spousal sexual assault as described in section 3128 (relating to spousal sexual assault), which has been

reported to a law enforcement agency having the requisite jurisdiction.

(4). The woman has reason to belief that the furnishing of notice to her spouse is likely to result in the infliction of bodily injury upon her spouse or by another individual.

Such statement need not be notarized, but shall bear a notice that any false statements made therein are punishable by law.

(c) **Medical Emergency.**--The requirements of subsection (a) shall not apply in the case of a medical emergency.

18 Pa. Con. Stat. Ann. § 3206(a) - (c). The husband notification provisions of this section are new to the Act.

268. "Spousal sexual assault" is defined as follows:

(a) sexual assault.-- A person commits a felony of the second degree when that person engages in sexual intercourse with that person's spouse:

(1) by forcible compulsion;

(2) by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution; or

(3) who is unconscious.

(b) Involuntary spousal deviate sexual intercourse.-- A person commits a felony of the second degree when that person engages in deviate sexual intercourse with that person's spouse:

(1) by forcible compulsion;

(2) by threat of forcible compulsion that would prevent resistance by a person of reasonable resolution; or

(3) who is unconscious.

18 Pa. Con. Stat. Ann. §3128 (1990 Supp.)

269. If the husband notification provisions of the Act were to go into effect, PaDOH has prepared a form to be filled out by married women seeking an abortion prior to performance of the procedure. This form reads as follows:

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

ABORTIONS: SPOUSAL NOTICE

CERTIFICATION REGARDING SPOUSAL NOTICE

I understand that as a married woman, I am required to notify my spouse of the fact that I am about to undergo an abortion, prior to obtaining such abortion, unless I am exempt from the notification requirements due to one of the reasons set forth below. Pursuant to this requirement, I hereby certify that:

CHECK APPROPRIATE BLANK(S)

_____ I have notified my spouse that I am about to undergo an abortion.

_____ I have not notified my spouse that I am about to undergo an abortion for the following reason(s):

_____ My spouse is not the father of the child.

_____ My spouse, after diligent effort, could not be located.

_____ The pregnancy is a result ofspousal sexual assault which has been reported to a law enforcement agency having the requisite jurisdiction.

_____ I have reason to believe that the furnishing of notice to my spouse is likely to result in the infliction of bodily injury upon me by my spouse or by another individual.

_____ I understand that any false statement made herein is punishable by law.

_____
Signature/Date

NOTICE: ANY FALSE STATEMENT MADE HEREIN IS PUNISHABLE BY LAW.

[Trial Testimony of Dr. Potrzebowski, Vol. III at 111; Defendants' Exhibit 48].

270. Dr. Potrzebowski was unable to explain why the Commonwealth felt it necessary to include the warning against criminal penalties on the spousal notice twice. [Trial Testimony of Dr. Potrzebowski, Vol. II at 134-35].

271. The woman making a false statement under section 3209 is subject to the penalties for a third degree

misdemeanor. The physician is subject to license suspension or revocation and civil or criminal penalties for violation of this provision. See 18 Pa. Con. Stat. Ann. § 3209(e).

272. ACOG has taken an official position against forced husband notification. [Trial Testimony of Dr. Allen, Vol. I at 66].

273. The vast majority of women consult their husbands prior to deciding to terminate their pregnancy. [Trial Testimony of Ms. Roselle, Vol. II at 67-68].

274. The requirement that a married woman notify her husband prior to having an abortion will cause delay in performance of the abortion procedure. Those women without full knowledge of the provisions of the Act

will be required to make two visits tothe abortion provider.

275. The Act does not define the term "after diligent effort" contained in 18 Pa. Con. Stat. Ann. § 3206(b)(2).

276. The requirement that a woman make a "diligent effort" to locate her husband in order to comply with section 3209 will delay compliance with section 3209. [Trial Testimony of Dr. Walker, Vol. II at 46].

277. The criminal and civil penalties of section 3209 will force physicians and counselors to interpret "diligent effort" in a narrow fashion in order to avoid civil and criminal liability, and to counsel the patient properly so that the patient would not be subject to criminal penalties. [Trial Testimony of Dr. Davidson, Vol.

I at 34-35; Trial Testimony of Dr. Bolognese, Vol. I at 143-44].

278. Section 3209(b)(4) only permits a woman to claim an exception from husband notification when she has reason to believe she is in danger of the infliction of bodily injury upon her by her husband or by another individual.

279. The "bodily injury" exception could not be invoked by a married woman whose husband, if notified, would, in her reasonable belief, threaten to (1) publicize her intent to have an abortion to family, friends or acquaintances; (b) retaliate against her in future child custody or divorce proceedings; (c) inflict psychological intimidation or emotional harm upon her, her children or other persons; (d) inflict bodily harm

on other persons such as children, family members or other loved ones; or (e) use his control over finances to deprive of necessary monies for herself or her children. [Trial Testimony of Dr. Walker, Vol. II at 23, 50].

280. Because of the difference in the definition of abuse, a woman protected from her husband by a restraining order pursuant to the Protection From Abuse Act or a child protected under the Juvenile Act and Child Protective Services Act may not fall within an exception to section 3209(b).

281. Studies reveal that family violence occurs in two million families in the United States. This figure, however, is a conservative one that substantially understates (because

battering is usually not reported until it reaches life-threatening proportions) the actual number of families affected by domestic violence.[25] In fact, researchers estimate that one of every two women will be battered at some time in their life. [Trial Testimony of Dr. Walker, Vol. II at 12, 21].

282. A wife may not elect to notify her husband of her intention to have an abortion for a variety of reasons, including the husband's illness, concern about her own health, the imminent failure of the marriage, or the husband's absolute opposition to the abortion. [Trial Testimony of Ms.

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25. See also Hodgson v. Minnesota, ___ U.S. _____, ____ n.25, 110 S.Ct. 2926, 2939 n.25, 58 U.S.L.W. 4957, 4963 n.25 (1990).

Roselle, Vol. II at 69-70].

283. The required filing of the spousal consent form would require plaintiff-clinics to change their counseling procedures and force women to reveal their most intimate decision-making on pain of criminal sanctions. The confidentiality of these revelations could not be guaranteed, since the woman's records are not immune from subpoena. [Trial Testimony of Ms. Roselle, Vol. II at 71-72].

284. Women of all class levels, educational backgrounds, and racial, ethnic and religious groups are battered. [Trial Testimony of Dr. Walker, Vol. II at 14].

285. Wife-battering or abuse can take on many physical and psychological forms. The nature and scope of the

battering can cover a broad range of actions and be gruesome and torturous. [Trial Testimony of Dr. Walker, Vol. II at 15; Trial Testimony of Ms. Dillon, Vol. III at 147-48].

286. Married women, victims of battering, have been killed in Pennsylvania and throughout the United States. [Trial Testimony of Dr. Walker, Vol. II at 17, 22].

287. Battering can often involve a substantial amount of sexual abuse, including marital rape and sexual mutilation. [Trial Testimony of Dr. Walker, Vol. II at 12-14, 17; Trial Testimony of Ms. Dillon, Vol. III at 155-56].

288. In a domestic abuse situation, it is common for the battering husband to also abuse the

children in an attempt to coerce the wife. [Trial Testimony of Dr. Walker, Vol. II at 12; Trial Testimony of Ms. Dillon, Vol. III at 151-52].

289. Mere notification of pregnancy is frequently a flashpoint for battering and violence within the family. The number of battering incidents is high during the pregnancy and often the worst abuse can be associated with pregnancy. [Trial Testimony of Dr. Walker, Vol. II at 41, 44; Trial Testimony of Ms. Dillon, Vol. III at 144]. The battering husband may deny parentage and use the pregnancy as an excuse for abuse. [Trial Testimony of.Ms. Dillon, Vol. III at 144].

290. Secrecy typically shrouds abusive families. Family members are instructed not to tell anyone,

especially police or doctors, about the abuse and violence. Battering husbands often threaten their wives or her children with further abuse if she tells an outsider of the violence and tells her that nobody will believe her. A battered woman, therefore, is highly unlikely to disclose the violence against her for fear of retaliation by the abuser. [Trial Testimony of Dr. Walker, Vol. II at 48; Trial Testimony of Ms. Dillon, Vol. III at 150-51, 160-62].

291. Even when confronted directly by medical personnel or other helping professionals, battered women often will not admit to the battering because they have not admitted to themselves that they are battered. [Trial Testimony of Dr. Walker, Vol. II at 13, 49].

292. Battered women are monitored very closely by their abusers. Battered women are often expected to explain any absence from the home or work. Therefore, the opportunities of battered women to disclose battering to others are few, if any. [Trial Testimony of Dr. Walker, Vol. II at 19, 43; Trial Testimony of Ms. Dillon, Vol. III at 157, 162-63].

293. Battered women would find it extremely difficult to get to an abortion clinic because of the problem of accounting for her time. A 24-hour waiting period would be especially harsh upon battered women, since she would have to make two trips to the clinic. [Trial Testimony of Dr. Walker, Vol. II at 57; Trial Testimony of Ms. Dillon, Vol. III at 157].

294. A woman in a shelter or safe

house unknown to her husband is not "reasonably likely" to have bodily harm inflicted upon her by her batterer, however her attempt to notify her husband pursuant to section 3209 could accidently disclose her whereabouts to her husband. Her fear of future ramifications would be realistic under the circumstances.

295. Marital rape is rarely discussed with others or reported to law enforcement authorities, and of those reported only few are prosecuted. [Trial Testimony of Dr. Walker, Vol. II at 23, 47, 48; Trial Testimony of Ms. Dillon, Vol. III at 154- 55].

296. It is common for battered women to have sexual intercourse with their husbands to avoid being battered. While this type of coercive sexual

activity would be spousal sexual assault as defined by the Act, many women may not consider it to be so and others would fear disbelief. [Trial Testimony of Dr. Walker, Vol. II at 22, 47-48, 55; Trial Testimony of Ms. Dillon, Vol. III at 155-56].

297. The marital rape exception to section 3209 cannot be claimed by women who are victims of coercive sexual behavior other than penetration. The 90-day reporting requirement of the spousal sexual assault statute, 18 Pa. Con. Stat. Ann. § 3128(c), further narrows the class of sexually abused wives who can claim the exception, since many of these women may be psychologically unable to discuss or report the rape for several years after the incident. [Trial Testimony of Dr. Walker, Vol. II at 13].

298. Because of the nature of the battering relationship, battered women are unlikely to avail themselves of the exceptions to section 3209 of the Act, regardless of whether the section applies to them. [Trial Testimony of Dr. Walker, Vol. II at 46-49].

299. Battered women are often victims of psychological abuse, including verbal degradation, food and sleep deprivation, isolation and monitoring. This psychological abuse would fall within the definition of psychological torture utilized by Dr. Walker and Amnesty International. However, such abuse does not fall within any exception to the husband notification requirement in the Act. [Trial Testimony of Dr. Walker, Vol. II at 18-19].

300. Battered women who experience serious psychological abuse, who are sexually abused by a way not covered by the sexual assault statute, and who are fearful of the physical and sexual abuse of their children would not be covered by the exceptions to the Act. [Trial Testimony of Dr. Walker, Vol. II at 48-50].

301. Physical and sexual abuse of children is an aspect of the battering relationship in over half of the cases studies by Dr. Walker. In addition, many batterers use economic coercion against women and children. [Trial Testimony of Dr. Walker, Vol. II at 20].

302. Many medical and surgical procedures, including, but not limited to, sterilization, prostrate operations and chemotherapy, affect the capacity of males to have children within the

marriage. The Commonwealth does not require that a husband notify his wife of his intent to obtain a vasectomy or other surgical procedure affecting his capacity to be a father. [Trial Testimony of Dr. Allen, Vol. I at 65]. Further the Commonwealth does not require a woman to notify her husband of other surgical procedures, such as a hysterectomy, which would affect her capacity to be a mother.

303. Women unable to reveal the battering or leave a battering relationship suffer from the psychological manifestations of battery called "battered women syndrome." Battered women syndrome is one form of Post-Traumatic Stress Disorder ("PTSD"), as defined in The Diagnostic and Statistical Manual of Mental Disorders,

3d edition (revised). [Trial Testimony of Dr. Walker, Vol. II at 30-31; Plaintiffs' Exhibit 89].

304. Among the psychological manifestations of PTSD in the case of battered women are "learned helplessness" and "the cycle of violence." [Trial Testimony of Dr. Walker, Vol. II at 24, 30- 31].

305. Under the theory of learned helplessness, the battered woman develops a coping strategy, rather thanan escaping mechanism, when she learns that her responses to the random and variable levels of abuse will not make a difference. [Trial Testimony of Dr. Walker, Vol. II at 24-30].

306. The battering ordinarily involves a three-phase recurring cycle of violence. First, there is a period of increasing tension in which the

abusive behavior can be classified as mild or moderate on a scale of one to ten. This is followed by a period of acute battering during which the battering can attain life-threatening or endangering proportions. Lastly, the battering relationship enters into a period of "loving contrition." The final stage reinforces and perpetuates the violence and the relationship. [Trial Testimony of Dr. Walker, Vol. II at 30-34; Plaintiffs' Exhibit 88].

307. Due to learned helplessness and the cycle of violence, battered women deny and minimize the abuse in order to avoid the pain associated with discussing it. Most battered women do not have the psychological ability to avail themselves of the exceptions of section 3209. [Trial Testimony of Dr. Walker, Vol. II at 40-41, 49].

308. A woman's personal perception of the consequences which will likely result from notifying her husband is likely to be accurate. [Trial Testimony of Dr. Walker, Vol. II at 45]. Forced husband notification would not improve communication within a battering relationship nor improve the marital integrity. Instead, it would foster negative and abusive communication and increase the likelihood that a woman would be seriously battered. Dr. Walker likened forced husband notification in a battering situation to providing the husband with a hammer with which he can beat his wife. [Trial Testimony of Dr. Walker, Vol. II at 44-46, 50].

(5) Determination of Gestational Age (section 3210)

309. Section 321 of the Act, as amended, provides as follows:

> Except in the case of a medical emergency which prevents compliance with this section, no abortion shall be performed or induced unless the referring physician or the physician performing or inducing it has first made a determination of the probable gestational age of the unborn child. In making such a determination, the physician shall make such inquiries of the patient and perform or cause to be performed such medical examinations and tests as a prudent physician would consider necessary to make or perform in making an accurate diagnosis with respect to gestational age. The physician who performs or induces the abortion shall report the type of inquiriesmade and the type of examination and tests utilized to determine gestational age of the unborn child and the basis for the diagnosis with respect to gestational age on forms provided by the department.

18 Pa. Con. Stat. Ann. § 3210(a).

310. Section 3210 does not identify which specific examinations or tests should be performed by a physician in making an "accurate" diagnosis of gestational age. Instead,

the Act requires the physician to perform those tests that a "prudent physician would consider necessary to make an accurate" determination of gestational age.

311. If this portion of the Act were to go into effect, PaDOH proposes to use a form which would require a physician to provide a "clinical determination of gestational age at time of abortion," as well as identify the "types of inquiries/examinations/tests utilized" and the "basis for diagnosis" of gestational age. [Trial Testimony of Dr. Potrzebowski, Vol. III at 99-100; Defendants' Exhibit 47C].

312. There are various methods of determining gestational age, including physical examination, patient medical history, and ultrasound. [Court's

Exhibit 1-A at ¶ 106]. However, gestational age can ordinarily be accurately determined by review of a woman's menstrual history and a pelvic examination. [Trial Testimony of Dr. Bowes, Vol. III at 78].

313. All plaintiffs make a determination of gestational age prior to performing an abortion. [Court's Exhibit 1-A at ¶ 107].

314. An accurate determination of gestational age is desirable to determine the possibility of viability of the fetus, to assess the health risks to the patient seeking the abortion, and to determine which abortion technique would be appropriate under the circumstances.

315. The plaintiff-clinics utilize the following methods of determining gestational age at the following charges:

a. RHCC -- Pelvic examination - $10 and ultrasound - $70.

b. AWC -- Medical history and pelvic examination which are included in the cost of the $280 fee for the abortion procedure and sonogram - $50.

c. WSC -- Date of last menstrual period as told to WSC by client and pelvic examination by physician performing abortion just prior to starting the abortion. Occasionally, when a client is unsure of her last menstrual period or is late in her first trimester, the physician will do a pelvic examination separate from the procedure of abortion.

d. PPSP -- Pelvic sizing is performed by the physician prior to each abortion procedure which is included in the fee for the abortion procedure. An ultrasound is performed on all patients

in their last two weeks of the first trimester to determine gestational sizing. This is done by a staff RN or Medical Assistant whose pay ranges from $8.60 to $13.60. Each ultrasound requires approximately fifteen minutes to perform. Other staff involvement would include telephone scheduling of appointment at $9 per hour and intake procedure at $9.80 per hour. Cost to patient is $25 to $50. The clinic would incur additional costs for supplies and equipment.

e. WHS -- Prior to the abortion, the length of the pregnancy during the first fourteen weeks is determined by the length of time since the first day of the last normal menstrual period. This is verified by pelvic examination prior to the performance of the abortion. No fee is charged for this

examination. If the woman is uncertain of the date of her last menses or the date indicates the pregnancy is greater than fourteen weeks since LMP, the length of pregnancy is determined by a pelvic examination at a fee of $30 and ultrasonography at a fee of $100. [Court's Exhibit 1-A at § 108].

316. PPSP performs sonograms if the gestational age is near the end of the first trimester. [Court's Exhibit 1-A at ¶ 112].

317. For abortions from 12 to 16 weeks from the last menstrual period an ultrasound is required at RHCC. [Court's Exhibit 1 at ¶ I4].

318. At Magee, an ultrasound or sonogram is used to determine gestational age for pregnancies beyond 12 weeks. [Court's Exhibit 1-A at ¶ 86].

319. At WHS, an ultrasound or

sonogram is used to determine gestational age for any pregnancies beyond 14 weeks. [Court's Exhibit 1-A at ¶ 87].

320. WSC never uses a sonogram in determining gestational age. Instead, gestational age is determined by questioning the woman and the performance of a pelvic examination by the physician. If an ultrasound is ordered, it is performed at another facility. [Court's Exhibit 1-A at ¶ 132].

321. AWC determines gestational age by a woman's menstrual history and pelvic examination and, if AWC is unclear of the length of the woman's pregnancy, it will do a sonogram. The fee for a sonogram is $50 but is frequently waived. [Court's Exhibit 1-A at ¶ 132].

322. Section 3210 does not require physicians to perform those tests which will provide the most accurate determination of gestational age.

323. Section 3210, if implemented, would not cause physicians or other abortion providers to alter their current practices in determining the gestational age of the fetus.

(6) Public Disclosure and Reporting Requirements (Sections 3207 and 3214)

324. PaDOH's Division of Health Statistics and Research ("the Division") is responsible for the receipt, compilation and storage of all forms submitted under the Act. The Division is comprised of two sections -- Statistical Registry Section and Statistical Support Section. The Statistical Registry Section is responsible for the collection and

processing of data, while the Statistical Support Section analyzes the data received and prepares the annual report. [Trial Testimony of Dr. Potrzebowski, Vol. III at 88-90].

325. The Division is responsible for five forms under the Act: (1) the Abortion Facility Registration Form [Defendants' Exhibit 45]; (2) the Abortion: Quarterly Facilities Report [Defendants' Exhibit 46]; (3) the Report of Induced Termination of Pregnancy Defendants' Exhibit 47B];[26] (4) the

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26. Defendants' Exhibit 47B is the form presently being used. Defendants' Exhibit 47A is a version of the form PaDOH intended to use prior to the preliminary injunction, and Defendants' Exhibit 47C is the version of the form PaDOH proposes to use should the injunction be lifted completely. [Trial Testimony of Dr. Potrzebowski, Vol. III at 98].

Abortions: Report of Complications [Defendants' Exhibit 44]; and (5) the Maternal Death Report. [Trial Testimony of Dr. Potrzebowski, Vol. III at 90].

326. The content of the forms is determined by PaDOH's interpretations of of data on induced terminations of pregnancy. [Trial Testimony of Dr. Potrzebowski, Vol. III at 98].

327. The Division and its employees are familiar with maintaining the confidentiality of various reports and records. PaDOH's "Policies and Procedures for Confidentiality and Data Release" and the Division's "Handbook of Policies and Procedures" both address the non-release of confidential information. [Trial Testimony of Dr. Potrzebowski, Vol. III at 96-97;

Defendants' Exhibits 41 and 42].

328. Under Pennsylvania law, the Division is directed to gather data and maintain such data's confidentiality in additional areas other than abortion. For example, records must be kept confidential, other than in limited, strictly supervised exceptions, under the Disease Prevention and Control Law of 1955, 35 Pa. Con. Stat. Ann. § 521.15 (Purdon 1977); the Vital Statistics Law of 1953, 35 Pa. Con. Stat. Ann. §§ 450.801, 450.805 (Purdon 1977); and the Pennsylvania Cancer Control, Prevention and Research Act, 35 Pa. Con. Stat. Ann. § 5636 (Purdon 1990 Supp.).

329. In respect to each set of forms, PaDOH follows the following standard procedure: (1) the envelope containing the form is opened and date stamped by a secretary in the Division;

(2) the secretary returns the form to the envelope and takes it to the desk of the person within the Division responsible for processing the form; (3) that person reviews the form for completeness, enters the data on her personal computer, and checks certain forms against a master list; (4) that person, if necessary, contacts the facility to obtain additional or clarifying information; (5) the form is placed into a locked cabinet. The cabinet and computer diskettes are locked when not in use. The computer is password controlled and only three other persons have the password. [Trial Testimony of Dr. Potrzebowski, Vol. III at 91-93, 95]. After the forms reach a certain number, they are placed in a secure room within the Division where they are kept for two years.

Thereafter, the forms are transferred to the Division's section of the state records center where they are preserved in accordance with a retention schedule. When in the state records center, these forms are only accessible to authorized personnel from the Division. [Trial Testimony of Dr. Potrzebowski, Vol. III at 126-28, 139-40]

330. At the end of the year, the Statistical Support Section is given access to the computer records for the purpose of preparing the annual report. The same security measures are in place. [Trial Testimony of Dr. Potrzebowski, Vol. III at 93].

330. PaDOH's annual reports do not release or reveal the names of any performing or referring physician, any facility that is submitting the reports, or any woman who has had an abortion.

[Trial Testimony of Dr. Potrzebowski, Vol. III at 97].

332. Ms. Wall of PPSP has no knowledge of any case where PaDOH released the identity of a physician who performs abortions. [Court's Exhibit 1-A at ¶ 121].

a. **Public Disclosure.**

333. Section 3207(b), as amended, provides:

> Within 30 days after the effective date of this chapter, every facility at which abortions are performed shall file, and update immediately upon any change, a report with the department, containing the following information:
>
> (1) Name and address of the facility.
>
> (2) Name and address of any parent, subsidiary or affiliated organizations, corporations or associations.
>
> (3) Name and address of any parent, subsidiary or affiliated organizations, corporations or associations having contemporaneous commonality of ownership, beneficial interest, directorship or officership with any other facility.
>
> The information contained in those reports which are filed pursuant to this subsection by facilities which receive State appropriated funds during the 12-calendar-month period immediately preceding a request to inspect or copy such reports shall be deemed public information. Reports filed by facilities which do not receive State appropriated funds shall only be available to law enforcement officials, the State Board of Medicine and the State Board of Osteopathic Medicine for use in the performance of their official duties. Any facility failing to comply with the provisions of this subsection shall be assessed by the department a fine of $500 for each day it is in violation hereof.

18 Pa. Con. Stat. Ann. § 3207(b).

334. Section 3207(b) of the Act was not amended by Act 64. However, the existing version of section 3207(b) is more narrowly drawn than its 1982 predecessor. Under the earlier version, all reports filed under this section were available for public inspection and

copying. See 1982 Pa. Laws 476, 493, § 1. The same applies to section 3214(f). Id. at 487-91.

335. Section 3214(f), as amended, provides:

> Every facility in which an abortion is performed within this Commonwealth during any quarter year shall file with the department a report showing the total number of abortions performed within the hospital or other facility during that quarter year. This report shall also show the total abortions performed in each trimester of pregnancy. Any report shall be available for public inspection and copying only if the facility receives State-appropriated funds within the 12-calendar-month period immediately preceding the filing of the report. These reports shall be submitted on a form prescribed by the department which will enable a facility to indicate whether or not it is receiving State-appropriated funds. If the facility indicates on the form that it is not receiving State-appropriated funds, the department shall regard its report as confidential unless it receives other evidence which causes it to conclude that the facility receives state-appropriated funds.

18 Pa. Con. Stat. Ann. § 3214(f).

336. PaDOH presently receives Abortion Facility Registration Forms [Defendants' Exhibit 45] and Quarterly Facilities Reports [Defendants' Exhibit 46] from abortion providers as required by the Act. Both forms would be made available for public inspection and copying if sections 3207(b) and 3204(f) were permitted to go into effect, but only if the facility received state appropriated funds within the preceding twelve month period. Currently, the forms are maintained in accordance with PaDOH's confidentiality procedures. [Trial Testimony of Dr. Potrzebowski, Vol. III at 93-94, 95, 109-11].

337. Records of state appropriations and expenditures are maintained and generally available at the present time under Pennsylvania's Right-to-Know Law, 65 Pa. Cons. Stat.

Ann. §§ 66.1 to 66.4 (Purdon 1990 Supp.), unless the information fits within the exceptions enumerated within the statute.

338. Facilities at which abortions are performed, including plaintiff-clinics, hospitals and physician's offices, have traditionally received funding in the form of Medicaid payments for a wide variety of medically necessary services, including a narrow class of abortions for victims of rape and incest and women with life-threatening conditions. [Trial Testimony of Ms. Roselle, Vol. II at 65, 73-74; Verification of Ms. Roselle at ¶¶ 7, 29].

339. Facilities where abortions are performed, including clinics, hospitals and physician's offices, may also receive state appropriated funds

for related medical care, as well as building and construction costs and other purposes unrelated to the provision of abortion services. [Trial Testimony of Ms. Roselle, Vol. II at 65-66, 117; Verification of Ms. Roselle at ¶ 29].

340. In 1987, AWC, which serves approximately 350 patients a month, received less than $4,000 in medical assistance funds. [Verification of Ms. Stengle at ¶¶ 2, 7].

341. In 1988, WHS, which performs 6500-7000 abortions annually and has 3,000 client contacts monthly, received medical assistance reimbursement for only 249 patients. [Trial Testimony of Ms. Roselle, Vol. II at 74; Verification of Ms. Roselle at ¶¶ 7, 31].

342. All clinics receiving state appropriated funds apply the funds only

to the services for which they are allocated.

343. Because facilities at which abortion services and counseling are offered are subjected to acts of harassment and violence, plaintiff-clinics are concerned that their reports will be open for public inspection and copying under sections 3207(b) and 3214(f). [Trial Testimony of Ms. Roselle, Vol. II at 93; Verification of Ms. Roselle at ¶ 30; Verification of Ms. Stengle at ¶ 37].

344. WHS, as well as other abortion providers, has experienced harassment from anti-abortionists, including daily leafleting or picketing by few individuals, occasional false patient visits, and "hate" mail. [Trial Testimony of Ms. Roselle, Vol. II at 93, 95, 100; Preliminary Injunction

Hearing Testimony of Ms. Roselle at 12-13; Preliminary Injunction Hearing Testimony of Ms. Stengle at 33-34]. Other incidents include: break-ins; picketing the residences of physicians and employees; bomb, kidnapping, and death threats against the clinics, employees and employee's family members. [Trial Testimony of Ms. Roselle, Vol. II at 96].

345. At WHS, the harassment has escalated since September 1988. During September 1988, anti-abortion protestors blockaded WHS's doors. This resulted in the arrests of 370 anti-abortion protestors. [Trial Testimony of Ms. Roselle, Vol. II at 96, 121].

346. Also since that time, the hostility of the threats has escalated. [Trial Testimony of Ms. Roselle, Vol. II at 101].

347. One year later, on September 30, 1989, five individuals carrying buckets of tar forced their way into WHS as an employee arrived for work. While inside, these individuals positioned themselves in the hallway of the main patient care area with their feet in the tar. In the ensuing arrests, the buckets of tar spilled onto the floor and splashed against the walls. Also, the tar was tracked across the carpet by police officers while making the arrests.[27] Repairs cost in excess of $27,000. [Trial Testimony of Ms. Roselle, Vol. II at 96-98, 100; Plaintiffs' Exhibit 86].

348. More recent sources of demonstration and harassment at WHS have

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27. Later, the trespassers were found guilty of criminal mischief, conspiracy and defiant trespass.

been organized by "Operation Multitude." Operation Multitude conducted three demonstrations at WHS on February 17, 1990, April 21, 1990, and in June 1990. During the February event, approximately 1200 anti-abortion demonstrators assembled outside WHS for five hours which crowded the sidewalks on both sides of the streets leading to the clinic. Women required pro-choice escorts to reach the doors of the clinic. For the first time in the experience of Ms. Roselle, women refused to attempt to reach the clinic on April 21, 1990 because of the hostility of the crowd. [Trial Testimony of Ms. Roselle, Vol. II at 98-100].

349. The anti-abortion incidents described herein are commonplace and most facilities providing abortion services are subjected to such

incidents. [Verification of Ms. Stengle at ¶ 37]. The harassment extends to the patients and staff members of the facilities.

350. Some anti-abortion demonstrations could adversely affect the ability of the clinic to operate their business and offer valuable services to the public, including such things as contraceptive counseling or AIDS testing.

351. I find plaintiff-clinics' fears of increased harassment if these reports are subject to public inspection to be reasonable.

352. Because of its concern with public disclosure of reports filed with PaDOH, AWC has determined that it will discontinue accepting all state appropriated funds, including medical assistance funds for poverty level

women. [Verification of Ms. Stengle at ¶¶ 37-38]. Other clinics may also seriously consider following the same course of action.

353. I find it likely that clinics will refuse to accept patients who are on medical assistance. The likely result will be that indigent patients who have been the victims of rape or incest or who suffer from a life-threatening condition will find it difficult, if not impossible depending upon what part of the state the woman resides, to obtain abortion services.

b. **The Reporting Requirements.**

354. Section 3214(a), as amended, states:

> **General Rule.** For the purpose of promotion of maternal health and life by adding to the sum of medical and public health knowledge through the compilation of relevant data, and to promote the Commonwealth's interest in protection of the unborn child, a report of each abortion performed

shall be made to the department on forms prescribed by it. The report forms shall not identify the individual patient by name and shall include the following information:

(1) Identification of the physician who performed the abortion, the concurring physician as required by section 3211(c)(2) (relating to abortion on unborn child of 24 or more weeks gestational age), the second physician as required by section 3211(c)(5) and the facility where the abortion was performed and of the referring physician, agency or service, if any.

(2) The county and state in which the woman resides.

(3) The woman's age.

(4) The number of prior pregnancies and prior abortions of the woman.

(5) The gestational age of the unborn child at the time of the abortion.

(6) The type of procedure performed or prescribed and the date of the abortion.

(7) Pre-existing medical conditions of the woman which would complicate pregnancy, if any, and, if known, any medical complication which

resulted from the abortion itself.

(8) The basis for the medical judgment of the physician who performed the abortion that the abortion was necessary to prevent either the death of the pregnant woman or the substantial and irreversible impairment of a major bodily function of the woman, where an abortion has been performed pursuant to section 3211(b)(1).

(9) The weight of the aborted child for any abortion performed pursuant to section 3211(b)(1).

(10) Basis for any medical judgment that a medical emergency existed which excused the physician from compliance with any provision of this chapter.

(11) The information required to be reported under Section 3210(a) (relating to determination of gestational age).

(12) Whether the abortion was performed upon a married woman and, if so, whether notice to her spouse was given. If no notice to her spouse was given, the report shall also indicate the reason for failure to provide notice.

18 Pa. Con. Stat. Ann. § 3214(a).

355. Act 31 required the reporting of the same basic information as the current version of section 3214(a) with the exception of that information tailored for specific provisions of the Act at the time. See 1988 Pa. Laws 262, 271-74, § 8. The 1982 version of the Act required that the report include the following additional information not presently contained in section 3214(a): (i) the woman's age, race and marital status; (ii) date of the woman's last menstrual period: (iii) the length and weight of the aborted fetus when measurable; (iv) how the abortion was paid for; (v) the date the determination of pregnancy was made; and (vi) other facts relating to specific sections of the 1982 version of the Act. See 1982 Pa. Laws 476, 487-91, § 1.

356. In addition to the information listed in section 3214(a),

PaDOH, if permitted, intends to collect other data, including marital status (even if the husband notification provisions were not in place); Hispanic origin; race; level of education; and date since last menses. [Trial Testimony of Dr. Potrzebowski, Vol. III at 100-01].

357. The reports are not public records within the meaning of Pennsylvania's Right-to-Know law, 65 Pa. Cons. Stat. Ann. §§ 66.1 to 66.4. 18 Pa. Con. Stat. Ann. § 3214(e)(2). Disclosure may be made to law enforcement officials only upon an order of the Court of Common Pleas after application showing good cause. Id. PaDOH's statistical report shall not lead to the disclosure of the identity of any physician, facility, or patient. See 18 Pa. Con. Stat. Ann. § 3214(e)(1).

358. PaDOH recognizes that this

information is not required by law, but maintains that it is authorized to seek more information than is required by law. [Trial Testimony of Dr. Potrzebowski, Vol. III at 100-01].

359. According to the testimony of Dr. Potrzebowski, this information is sought to (1) be consistent with the federal standards for the collection of data on induced terminations of pregnancy which were developed by the Center for Disease Control and (2) better study the three outcomes of pregnancy (live births, fetal deaths, and induced terminations of pregnancy) for which the Division collects data. [Trial Testimony of Dr. Potrzebowski, Vol. III at 101-02, 107; Defendants' Exhibit 43 (Handbook on the Reporting of Induced Terminations of Pregnancy ("Federal Handbook"))].

360. The federal government, through the National Center for Health Statistics, United States Department of Health and Human Services has prepared a "Standard Report of Induced Termination of Pregnancy" ("Federal Standard Report") which is intended to serve as a model for the states. Other than requiring some information pursuant to the Act, Pennsylvania's "Report of Induced Termination of Pregnancy" ("Pennsylvania Report") [Defendants' Exhibit 47C] is virtually identical to the Federal Standard Report. [Defendants' Exhibit 43 at 14].

361. The Federal Handbook states:

> Data from reports of induced termination of pregnancy provide unique information on the characteristics of women having induced abortions. Uniform annual data of such quality are nowhere else available. Medical and health information is provided to evaluate risks associated with

induced abortion at various lengths of gestation and by the type of abortion procedure used. Information on the characteristics of the women is used to evaluate the impact that induced abortion has on the birth rate, teenage pregnancy, and out-of-wedlock births. The data also help measure the role that induced abortion plays in birth prevention as compared with contraception. Because these abortion data provide information necessary to promote and monitor health, it is important that the forms be completed carefully.

[Defendants' Exhibit 43 at 2].

362. Both the Pennsylvania Report and the Federal Standard Report request the information listed in paragraph 356. The items of information required on the Pennsylvania Report but not required on the Federal Standard Report are: name of the referring physician and medical complications information.

363. Marital status, race and date of last normal menses are elements of

"the woman's personal history." Thornburgh, 476 U.S. at 766, 106 S.Ct. at 2181.

364. Abortion is another "pregnancy outcome," in addition to births and fetal death, upon which the Division of PaDOH gathers information. [Court's Exhibit 1-A at ¶ I04].

365. On the Certificate for Fetal Death which must be submitted to PaDOH on each instance of fetal death after 16 weeks of gestation, the physician or reporting entity must include information concerning Hispanic origin, race, educational background of the mother and father, marital status, and date of last normal menses. [Defendants' Exhibit 52].

366. On the Certificate of Live Birth which must be submitted to PaDOH upon each instance of live birth, the

physician or reporting entity must include information concerning Hispanic origin, race, educational background of the mother and father, marital status, and date of last normal menses. [Defendants' Exhibit 53].

367. Thirty-three states and New York City collect information on marital status and race of women having induced terminations of pregnancies; thirty-two states and New York City collect information concerning the date of last menses; twenty-eight states and New York City collect information relating to educational background; and sixteen states and New York City collect information concerning Hispanic origin. [Trial Testimony of Dr. Potrzebowski, Vol. III at 105-06].

368. As part of the patient's medical history, two (one of which makes

disclosure of this information optional) of the plaintiff-clinics collects data concerning the abortion patient's education, religion, and ethnic group. Three of the plaintiff-clinics collect information concerning the abortion patient's marital status and all of the plaintiff-clinics collect information concerning the patient's menstrual history. [Plaintiffs' Exhibits 6, 12, 18, 36, 44].

369. The requirement that the identity of the referring physician or agency be identified serves no legitimate scientific purpose.

370. Many physicians who refer patients for abortions are extremely protective of their anonymity because of fears (often based upon past experience) that any kind of documentation or record-keeping connecting them with any

phase of the abortion decision could have adverse effects on their medical practices and patients or their ability to reside peacefully in their communities. [Preliminary Injunction Hearing Testimony of Ms. Roselle at 20-21; Verification of Ms. Roselle at ¶ 36; Verification of Ms. Stengle at ¶ 42].

371. There are two medical doctors who, although they do not perform abortions, refer clients to WHS for abortions on the strict condition that WHS not use their names in any of its reports. These doctors insist upon this because each has been subjected to public abuse and harassment in the past. Under no circumstances would either doctor refer any patients to WHS or any other clinic if his name is reported under section 3214(a) even if there were no risk of public disclosure

of the report. [Preliminary Injunction Hearing Testimony of Ms. Roselle at 21; Verification of Ms. Roselle at ¶ 37]. Even though the information is available to these doctors, their patients would be unable to receive information concerning abortion services from their own physician and these women would have to go elsewhere for this information.

372. Several of AWC's current referring physicians will not permit AWC to send correspondence to their offices for fear that members of their own staffs would divulge to anti-abortion groups that they refer patients for abortions. [Verification of Ms. Stengle at ¶ 42]. One doctor has discontinued referring patients to AWC because of threats from anti-abortionists. [Verification of Ms. Stengle at ¶ 44].

373. On occasion the Division has had to contact a physician directly concerning forms submitted after the performance of an abortion, even when the facility at which the procedure was performed has a contact person that ordinarily handles such inquires. [Trial Testimony of Dr. Potrzebowski, Vol. III at 133].

374. Many physicians that have performed abortions have been subjected to harassment from anti-abortion demonstrators. As a result some physicians have ceased performing abortions. [Verification of Ms. Roselle at ¶ 37; Verification of Ms. Stengle at ¶ 41].

375. For this reason, some physicians reasonably prefer to keep the fact that they perform abortions out of the realm of public information.

[Preliminary Injunction Hearing Testimony of Ms. Stengle at 39; Verification of Ms. Stengle at ¶ 42].

376. One physician that performed abortions at AWC prior to the enactment of the new Act has discontinued working for AWC out of fear of public disclosure. Further, he has stopped performing abortions in his private practice as well. [Preliminary Injunction Hearing Testimony of Ms. Stengle at 39; Verification of Ms. Stengle at ¶ 43].

377. No physician has stopped performing abortions for PPSP because her or his identity was included on the Individual Reporting Form to PaDOH. [Court's Exhibit 1-A at ¶ 120].

378. Ms. Hollos, the Executive Director of WSC, knows of no physicians who have stopped performing abortions

because their identity is on the Pennsylvania Individual Report of Termination of Pregnancy Form. [Court's Exhibit 1-A at ¶ 131].

379. The evidence of record persuades me that the expectation of plaintiff-clinics that referring physicians and, to a lesser extent, performing physicians will terminate their relationship with the clinics is reasonable.

380. Section 3214(a) requires a physician who has performed an abortion to report the basis for his medical judgment to support his determination of gestational age, including the tests performed, under section 3210(a) or his conclusion that the abortion was necessary to prevent the death or a serious risk of substantial and irreversible impairment of a major

bodily function under any of the sections of the Act. This subsection also requires that the physician report whether a married patient informed her husband she was undergoing an abortion and, if not, the reason for her failure to do so.

381. These provisions of section 3214(a) serve no useful scientific purpose and unjustifiably interfere with the physician's exercise of his or her best medical judgment. [Preliminary Injunction Hearing Testimony of Dr. Dratman at 58-59].

382. Compliance with section 3214(a) costs WHS approximately $12,000 annually. [Trial Testimony of Ms. Roselle, Vol. II at 72-73].

383. Section 3214(h) requires every physician called upon to provide medial care and treatment to a woman suffering

from medical complications resulting from an abortion or attempted abortion to file a report with PaDOH within thirty days of first seeing the patient. See 18 Pa. Con. Stat. Ann. §3214(h).

384. No other surgical procedure has a complications reporting requirement. [Verification of Dr. Dratman at ¶ 14].

385. If a patient is treated by more than one physician, a single abortion complication may be reported by two or more treating physicians pursuant to section 3214(h). Since the reports omit the identity of the patient, they cannot be matched with complication reports filed by other physicians. Also, since complications from the abortion procedure can also be reported on the Pennsylvania Report, the same problem exists for these reports. This

may result in double counting of complications from abortion procedures.

386. Some women are hesitant to advise a physician, at least initially, that they have had an abortion because of the stigma and harassment emanating from anti-abortionists. This may cause physicians to provide inappropriate treatment for post-abortion symptoms or complications. Still other women delay in seeking post-abortion medical care for a complication. Thus, because of the delay, a minor problem may progress into a serious medical problem. [Verification of Dr. Dratman at ¶ 17, 18, 20].

387. While the problems noted above may result in a degree of misinformation or unreliable reporting of post-abortion complications, I conclude that data received will not be statistically

meaningless. The information sought, though not perfectly collected, is relevant to a legitimate medical and public health purpose.

III.

DISCUSSION

THE CONSTITUTIONAL STANDARD

The hostility of Pennsylvania's legislature to the protection of a woman's right of privacy to choose abortion is apparent from the history of the legislation purporting to regulate abortion in Pennyslvania. See supra at 5-11. In 1986, the Supreme Court determined that "[c]lose analysis of [the] provisions of [the Act] . . . shows that they wholly subordinate constitutional privacy interests and concerns with maternal health in an effort to deter a woman from making a

decision, that with her physician, is hers to make." Thornburgh, 476 U.S. at 759, 106 S.Ct. at 2178. Of the informed consent requirements of the 1982 verson of the Act, the Supreme Court determined that the information sought was not "medical information that is always relevant to the woman's decision,and it may serve only to confuse and punish her and to heighten her anxiety, contrary to accepted medical practice." Id. at 762, 106 S.Ct. at 2179. Similarly, when addressing the reporting requirements, the Court stated that "the reports required under the Act before us today go well beyond the health-related interests that served to justify" them and "raise the specter of public exposure and harassment of women . . . [and] pose an unacceptable danger of deterring the exercise" of a woman's

right to end a pregnancy. Id. at 766, 767-68, 106 S.Ct. at 2181, 2182.

This hostility is equally apparent in the 1988 and 1989 amendements to the Act. In fact, substantial portions of Act 64 are nothing more than a reenactment of provisions of the Act found unconstitutional by the Third Circuit and United States Supreme Court not too long ago in Thornburgh. Clearly, the Commonwealth of Pennsylvania seeks to challenge the very foundation of Thornburgh and those cases that preceded it, including Roe v. Wade.

Without question, the issue of abortion has generated much debate and controversy over the past several years. And, undoubtedly, it will likely engender continued debate and controversy over the next several years -- perhaps decades. However, my

function is not to debate the philosophical and moral dilemmas raised by a decision which Justice Blackmun aptly described as follows:

> Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision -- with the guidance of her physician and within the limits specified in Roe -- whether to end her pregnancy. A woman's right to make that choice freely is fundamental. Any other result, in our view, would protect inadequately a central part of the sphere of liberty that our law guarantees equally to all.

Thornburgh, 476 U.S. at 772, 106 S.Ct. at 2184. Instead, my function is to "uphold the law even when its content gives rise to bitter dispute." Id. at 771, 106 S.Ct. at 2184; see also Cooper v. Aaron, 358 U.S. 1, 78 S.Ct. 1401, 3 L.Ed. 2d 5 (1958).

Defendants seem to argue that the

constitutional standard applicable to judicial review of abortion regulations has somehow been modified by recent Supreme Court decisions. For reasons explained fully below, I most respectfully disagree. Whatever the Supreme Court may decide to do with this issue in the future, one thing is presently clear -- many of the challenged provisions of the Act are unconstitutional under Roe v. Wade and its progeny, including Thornburgh. "[O]nly [the Supreme] Court may overrule one of its precedents," Thurston Motor Lines, Inc. v. Jordan K. Rand Ltd., 460 U.S. 533, 535, 103 S.Ct. 1343, 1344, 75 L.Ed. 2d 260 (1983), for "unless we wish anarchy to prevail within the federal judicial system, a precedent of [the Supreme] Court must be followed by lower federal courts no matter how misguided

the judges of those courts think it to be." Hutto v. Davis, 454 U.S. 370, 375, 102 S.Ct. 703, 705, 70 L. Ed. 2d 556 (1982). The Supreme Court has recently stated:

> If a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some line of decisions, the Court of Appeals should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.

Rodriguez de Quijas v. Shearson/American Express, Inc., ____ U.S. ____, ____, 109 S.Ct. 1917, 1921, 104 L.Ed. 2d 526 (1989); see also National Ass'n for the Advancement of Colored People v. Medical Center, Inc., 657 F.2d 1322, 1329-30 (3d Cir. 1981) ("The prerogative of overruling its cases rests with the Supreme Court, and not with us").

Relying upon prior cases which held

that the fundamental constitutional right of privacy which guarantees freedom of personal choice in matters of marriage and family life, see, e.g., Fisenstadt v. Baird, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed. 2d 349 (1972) (Massachusetts statute permitting married persons to obtain contraceptives to prevent pregnancy but preventing distribution of contraceptives to single persons for same purpose was unconstitutional); Loving v. Virginia, 388 U.S. 1, 87 S.Ct. 1817, 18 L.Ed. 2d 1010 (1967) (invalidating Virginia miscegenation statute which prohibited marriages between people solely on the basis of race); Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed. 2d 510 (1965) (Connecticut statute prohibiting use of contraceptives unconstitutionally intrudes upon the

right of marital privacy), the Supreme Court concluded that a woman's right to choose an abortion is encompassed in that right. Roe v. Wade, 410 U.S. at 153, 93 S.Ct. at 726. In the nearly two decades since the landmark decision of Roe v. Wade was announced, this basic principle has frequently been reaffirmed. See, e.g., Thornburgh, 476 U.S. at 759, 106 S.Ct. at 2178; Akron, 462 U.S. at 420 n.1, 103 S.Ct. at 2487 n.1.

This fundamental right may be significantly limited only where the state demonstrates that its regulation is narrowly drawn to serve a compelling state interest. Casey I, 686 F. Supp. at 1125; see also Roe v. Wade, 410 U.S. at 155, 93 S.Ct. at 728. Where abortion regulations do not impose a legally significant burden, the state need only

show a rational basis for the regulation. American College I, 552 F. Supp. at 796. However, a state may not, under the pretense of protecting maternal health or potential life, restrict a woman's right to obtain an abortion or otherwise intimidate her into continuing her pregnancy. Thornburgh, 476 U.S. at 759, 106 S.Ct. at 2178. Simply stated, "[p]rovisions which wholly subordinate constitutional privacy interests and concerns with maternal health in an effort to deter a woman from exercising her right to choose abortion will not be tolerated." Casey I, 686 F. Supp. at 1125 (citing Thornburgh).

"[R]estrictive state regulation of the right to choose abortion, as with other fundamental rights subject to searching judicial examination, must be

supported by a compelling state interest." Akron, 462 U.S. at 427, 103 S.Ct. at 2491; see also Roe v. Wade, 410 U.S. at 155, 93 S.Ct. at 728. In the context of a woman's right to elect to terminate her pregnancy, two compelling state interests have been identified -- the protection of a fetus capable of meaningful life and the protection of maternal health. American College II, 737 F.2d at 291. Recognizing other interests in cases involving minors -- "the interest in the welfare of the pregnant minor, the interest of the parents, and the interest of the family unit" -- the state may limit the right of a minor woman to obtain an abortion in a manner which would not be permissible in the case of an adult.[28]

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28. I will discuss these interests in greater detail when addressing section 3206 of the Act relating to parental informed consent.

Id. at 296. The relative "strength" of either of these interests varies depending upon the trimester of pregnancy involved.[29]

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29. Critics of Roe v. Wade argue that the critical elements of its framework -- trimesters and viability -- are somehow inconsistent with our Constitution and unworkable in practice. There is certainly room for disagreement over this complex issue. But "[t]o overturn a constitutional decision is a rare and grave undertaking. To overturn a constitutional decision that secured a fundamental personal liberty to millions of persons would be unprecedented in our 200 years of constitutional history." Webster, ___ U.S. at ____, 109 S.Ct. at 3078 (Blackmun, J., dissenting in part and concurring in part).

The trimester framework provides a mechanism, in the context of abortion, from which the right to privacy can be restricted so as to accommodate, when appropriate, the state's legitimate interests in protecting maternal health and in preserving potential human life. "[E]stablishing benchmarks and standards with which to evaluate the competing claims of individuals and government, lies at the very heart of constitutional adjudication." Id. at ___ 109 S.Ct. at 3073.

(... continued)

"Because abortion is a medical procedure requiring the advice and assistance of competent, trained medical personnel, a woman cannot exercise her fundamental right alone." American College II, 737 F.2d at 283. In the first trimester, only regulations which do not significantly burden the woman's decision and are justified by important state objectives will be permitted.

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29. (... continued)

Justice Scalia attacks the trimester as an improper creation of "an Abortion Code," Hodgson, 110 S.Ct. at 2960, 58 U.S.L.W. at 4974 (Scalia, J., dissenting in part and concurring in judgment in part); see also Webster, ____ U.S. at _____, 109 S.Ct. at 3064 (Scalia, J., dissenting in part and concurring in judgment in part). Isn't it a court's function to draw narrow differentiations in all areas, including the rights of prisoners and criminal defendants, of constitutional law?

Finally, some, in the past, have argued that Roe v. Wade was "on a collision course with itself." See Akron, 462 U.S. at 458, 103 S.Ct. at

(... continued)

Ashcroft, 462 U.S. at 489-90, 103 S.Ct. at 2523-2524. In light of the relative simplicity and safety of the abortion procedure, regulations that restrict competent medical personnel do not appreciably advance the state's interest in maternal health. Akron, 462 U.S. at 428-30 & n.11, 434, 103 S.Ct. at 2492 & n.11, 2495. Due to the absence of a compelling state interest in the first trimester, the abortion decision must be free from state interference and its effectuation must be left to the woman

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29. (... continued)

2507 (O'Connor, J., dissenting). The presently prevailing medical information establishes that the development of the crucial organs necessary for extrauterine survival occurs during the 23rd or 24th week of gestation. "The threshold of fetal viability is, and will remain, no different from what it was at the time Roe was decided. Predictions to the contrary are pure science fiction." Webster, ___ U.S. at ___ n.9, 109 S.Ct. at 3075 n.9 (Blackmun, J., dissenting in part and concurring in part).

and the medical judgment of her attending physician. Id.; Roe v. Wade, 410 U.S. at 163-64, 93 S.Ct. at 732. However, certain regulations which do not significantly impact upon a woman's decision in the first trimester may be permissible, if the state can prove that they further an important state interest without interfering with the woman's choice and the independent medical judgment of her physician. See Ashcroft, 462 U.S. at 486-90, 103 S.Ct. at 2522-25; Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 65-67, 79-81, 96 S.Ct. 2831, 2839-40, 2845-46, 49 L.Ed. 2d 788 (1976) ("Danforth").

At approximately the beginning of the second trimester of pregnancy, the state's interest in promoting maternal health becomes compelling. "[T]o the

extent that the regulation reasonably relates to the preservation of maternal health," the state may justify regulations which significantly burden the woman's right to terminate her pregnancy. Roe v. Wade, 410 U.S. at 164, 93 S.Ct. at 732. However, these regulations must not depart from accepted medical practice, Akron, 462 U.S. at 431, 103 S.Ct. at 2493; see also American College II, 737 F.2d at 292, and cannot "directly restrict[] a woman's decision whether or not to terminate her pregnancy." Colautti v. Franklin, 439 U.S. at 386, 99 S.Ct. at 681.

Finally, at "viability," a state may regulate, and even proscribe, abortion in the name of its interest in the potentiality of human life, except when necessary, in appropriate medical

judgment, for the preservation of the life or health of the mother. Id. at 387-88, 99 S.Ct. at 681-82; Roe v. Wade, 410 U.S. at 164-65, 93 S.Ct. at 732. The point of viability is not for this court or the legislature to determine. Instead, this task must be left to the attending physician's medical judgment as to whether, based upon the facts of the particular case before him or her, there is "a reasonable likelihood of the fetus' 'sustained survival' and 'meaningful life' outside the womb." American College II, 737 F.2d at 292 (quoting Colautti v. Franklin, 439 U.S. at 386, 99 S.Ct. at 681).

Once the plaintiffs have demonstrated that a regulation imposes a significant burden on the woman's right to an abortion, the Commonwealth has the burden of proving that the regulation is

narrowly tailored to the precise compelling interest at stake. Casey I, 686 F. Supp. at 1125-26; see also Akron, 462 U.S. at 433-34, 103 S.Ct. at 2494-95; Roe v. Wade, 410 U.S. at 155, 165, 93 S.Ct. at 728, 732; American College II, 737 F.2d at 292. For example, the Commonwealth must make a reasonable effort to limit the effect of its regulation to that portion of the trimester during which its interests will be furthered. Akron, 462 U.S. at 434, 103 S.Ct. at 2494-95.

The three recent Supreme Court decisions relating to abortion regulation have not changed or modified these basic tenets. In Webster, the Supreme Court reviewed provisions of the Missouri statute which: (1) bans the performance of abortions by public employees and in public facilities

except to save the life of the mother; and (2) requires physicians to perform "such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child" on any woman the physician had reason to believe was 20 weeks or more pregnant. In addition, the Court also considered the preamble to the Missouri statute which declares that life begins at conception.[30]

The Court determined that "none of the challenged provisions of the Missouri Act properly before [it]

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30. In respect to the preamble, the majority of the Court determined that it need not address its constitutionality because the clause was "abortion-neutral." See Webster, ____ U.S. at ____ 109 S.Ct. at 3049-50; id. at ___ , 109 S.Ct. at 3059 (O'Connor, J., concurring).

conflict with the Constitution." Webster, ___ U.S. at ___, 109 S.Ct. at 3059. Indeed, a plurality of the Court was prepared to modify Roe v. Wade, but only "to the extent" required to uphold the Missouri statute. Id. Providing the decisive fifth vote, Justice O'Connor, declined the plurality's invitation to revisit Roe v. Wade even in the slightest degree. Concurring in judgment on this issue, Justice O'Connor stated "[t]he Court today has accepted the State's every interpretation of [Missouri's] abortion statute and has upheld, under our existing precedents, every provision of the statute which is properly before us." Id. at ___, 109 S.Ct. at 3061 (O'Connor, J., concurring in judgment) (emphasis added). After Webster the standard of review for abortion legislation remained

unchanged. See id. at ___, 109 S.Ct. at 3067 (Blackmun, J., dissenting) ("the Court extricates itself from [Webster] without making a single, even incremental, change in the law of abortion"); see also Lewis v. Pearson Foundation, Inc., ___ F.2d ___ (slip op. at 5) (8th Cir. July 10, 1990) (Webster and Hodgson both "recognized the continuing viability of Roe v. Wade" and, therefore, Roe v. Wade remains controlling); Massachusetts v. Secretary of Health and Human Services 899 F.2d 53, 54 (1st Cir. 1990) ("The [Webster] Court relied upon and reaffirmed the holdings of McRae and Maher v. Roe . . . and upheld the validity of Roe v. Wade"); Arnold v. Board of Educ. of Escambia County, Alabama, 880 F.2d 305, 311 & n.6 (11th Cir. 1989) (reaffirming the principles of Roe v. Wade and

concluding that Webster did not affect its decision); Florida Women's Medical Clinic, Inc. v. Smith, No. 79-6063, slip op. at 2 (S.D. Fla. Aug. 1, 1990) ("Defendant's[']reading of Webster is simply wrong. Webster did not overrule or modify Roe"); In Re Air Crash Disaster at Detroit Metropolitan Airport on August 16, 1987, 737 F. Supp. 427, 429 (E.D. Mich. 1989) ("The Webster Court neither overturned Roe with respect to viability nor found as a matter of law that viability occurs at twenty weeks").

Further, nothing in Hodgson or Ohio v. Akron Center for Reproductive Health, ____ U.S. ____, 110 S.Ct. 2972, 58 U.S.L.W. 4979 (1990), the Supreme Court's recent decisions dealing with the rights of minors to obtain abortions, modifies Roe v. Wade. In

these two cases, the Court struck down a Minnesota statute requiring minor women to notify both their parents, without a judicial by-pass procedure, before obtaining an abortion; upheld another section of the Minnesota statute which required two-parent notice but included judicial by-pass procedures; upheld a 48-hour waiting period, after notification was given to the parents, for all minor women; upheld Ohio's single-parent notice requirement which included a by-pass mechanism; and upheld Ohio's requirement that the physician notify the parent personally.[31]

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31. Justice Scalia's understanding of the opinions in Hodgson and Ohio is as follows:

> One Justice holds that two-parent notification is unconstitutional (at

(... continued)

Neither Hodgson nor Ohio overrules Roe v. Wade. Justice Marshall wrote:

> Roe remains the law of the land. Indeed, today's decision reaffirms the vitality of Roe, as five Justices have voted to strike down a state law restricting a woman's right to abortion. Accordingly, to be constitutional, the rigorous test [of strict judicial scrutiny].

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31. (... continued)

> least in the present circumstances) without judicial bypass, but constitutional with bypass . . . ; four Justices would hold that two-parent notification is constitutional with or without bypass . . . .; four Justices would hold that two-parent notification is unconstitutional with or without bypass, though the four would apply two different standards . . . .; six Justices hold that one-parent notification with bypass is constitutional, though for two different sets of reasons . . . .; and three Justices would hold that one-parent notification with bypass is unconstitutional . . . .

Hodgson, 110 S.Ct. at 2960, 58 U.S.L.W. at 4973-74 (Scalia, J., concurring in judgment in part and dissenting in part).

Hodgson, 110 S.Ct. at 2952, 58 U.S.L.W. at 4969 (Marshall, J., concurring in part, concurring in judgment in part, and dissenting in part) (citations omitted).

Moreover, in neither case did a majority of the Court articulate a new standard of review in abortion cases. In Hodgson, Justice Kennedy, joined by three other members of the Court, upheld the by-pass procedure because it "comports in all respects with our precedents . . . . In providing for the bypass, Minnesota has done nothing other than attempt to fit its legislation into the framework that we have supplied in our previous cases." Id. at 2970, 58 U.S.L.W. at 4978. Once again, the critical fifth vote came from Justice O'Connor. Justice O'Connor's opinion

relied upon the Court's prior decisions in Danforth and Bellotti v. Baird, 443 U.S. 622, 99 S.Ct. 3035, 61 L.Ed. 2d 797 (1979) ("Bellotti II") in which the Court approved the use of a by-pass mechanism to ameliorate the unconstitutional burdens imposed by parental consent statutes. Id. at 2949-50, 58 U.S.L.W. at 4968 (O'Connor, J., concurring). In Ohio, the majority opinion concluded that the Ohio statute was constitutional because it "meets the requirements for parental consent statutes in Danforth, Bellotti, Ashcroft, and Akron." Ohio, 110 S.Ct. at 2979, 58 U.S.L.W. at 4982. Finally, a majority of the Court emphasized that its opinions in Hodgson and Ohio did not conflict or modify Akron. See id. at 2983, 58 U.S.L.W. at 4984 ("The distinction between notifying a minor's

parents and informing a woman of the routine risks of an abortion has ample justification"); see also Hodgson, 110 S.Ct. at 2944 n.35, 58 U.S.L.W. at 4965 n.35.

With these principles in mind, I turn to the specific challenges raised by plaintiffs in this action.

THE DEFINITION OF MEDICAL EMERGENCY

As noted above, the Commonwealth may not adopt abortion regulations which depart from accepted medical practices. Akron, 462 U.S. at 434, 103 S.Ct. at 2494-95; American College II, 737 F.2d at 292. At every stage of the pregnancy, the woman's health must always remain the paramount consideration. See Colautti v. Franklin, 439 U.S. at 400, 99 S.Ct. at 688; see also American College II,

737 F.2d at 300. For this reason, the Commonwealth's interest in promoting the integrity of the marital relationship and the prenatal life of a spouse's child (assuming that such a legitimate interest does in fact exist) or encouraging informed consent and parental involvement in abortion decisions must take the back seat to any immediate and serious threat to maternal health. Therefore, to pass constitutional muster, regulations of a woman's right to choose to terminate her pregnancy must contain an adequate exception for medical emergencies. Casey I, 686 F. Supp. at 1137.

While the Act does contain an exception for medical emergencies, I find that is far from adequate. The definition of medical emergency within the Act interferes with the physician's

independent medical judgment. Without question, the definition of medical emergency is more restrictive than any other as applied in medical situations. Compare 18 Pa. Con. Stat. Ann. § 3203 with 35 Pa. Con. Stat. Ann. § 6923 and Findings of Fact (¶ 152), supra at 55-56. previously, I concluded:

> [T]he narrow definition of medical emergency contained in Section 3203 may compel a physician to act against his own best judgment and creates an unconstitutional trade off between the woman's health and the life or health of the fetus, or between the minor's health and the involvement of her parent in the abortion decision.

Casey I, 686 F. Supp. at 1137. This conclusion applies with equal force today. If anything, the record established herein makes this conclusion more certain.

Under the Act, the physician may only act in the best interests of his or her patient, if a delay would create a

"serious risk of substantial and irreversible impairment of [a] major bodily function" or death. At the risk of license suspension or revocation, as well as rather substantial potential criminal penalties, a physician is asked under the Act to proceed with the care of his or her pregnant patient in a manner inconsistent with his or her best medical judgment and incompatible with the best interests of his or her patient. This trade-off cannot be tolerated.

Defendants argue that the plaintiffs cannot demonstrate any situations in which a pregnant woman would be suffering from a condition requiring immediate medical care under generally accepted medical standards that would not also fall within the definition of medical emergency. The record before me

is very much to the contrary. Plaintiffs have identified three serious conditions, e.g. preeclampsia, inevitable abortion, and premature ruptured membrane, arising out of pregnancy that could pose a serious threat to a woman's health without creating a serious risk of substantial and irreversible impairment to a major bodily function. In such instances, delay might cause a risk of an impairment to a bodily function, but not a "serious risk of substantial and irreversible impairment to major bodily function." A pregnant woman, or any other person for that matter, should not be required to bear that risk. The Act's definition of medical emergency would hinder a physician's ability to respond rapidly to emergency circumstances and cause delay which could jeopardize a woman's health.

Defendant's also argue that the definition of medical emergency in the Act is less restrictive than the definition of medical emergency contained in the Missouri statute upheld in Hodgson. This argument is without merit. Without question, the Missouri statute does narrowly define the term "medical emergency," however, neither the lower courts nor the Supreme Court had occasion to consider its constitutionality.

I will, therefore, permanently enjoin the enforcement of all provisions of the Act containing the term "medical emergency."[32] Since this conclusion

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32. I decline to reach the merits of plaintiffs' vagueness argument. However, I note that the Supreme Court has stated that a statute is unconstitutionally vague if "'it fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the

enjoins all those provisions challenged by plaintiffs substantively, I technically need not reach the merits of the remaining challenges to the Act. However, to avoid potential piecemeal appellate review, I shall address the remainder of the issues raised.

TWENTY-FOUR HOUR WAITING PERIOD

Section 3205 of the Act requires a mandatory 24-hour delay between the time

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32. (... continued)
statute' . . . [and] is so indefinite that 'it encourages arbitrary and erratic arrests and convictions.'" Colautti v. Franklin, 439 U.S. at 390, 99 S.Ct. at 683. It can be persuasively argued that, like the provision at issue in Colautti, the Act "conditions potential criminal liability on confusing and ambiguous criteria" and, therefore, presents "serious problems of notice, discriminatory application, and chilling effect on the exercise of constitutional rights." Id.

the woman's consent for an abortion is obtained and the actual time the procedure is performed. Section 3205 applies to all abortions regardless of which trimester of pregnancy is involved. Essentially, the Commonwealth seeks a decision which would effectively overrule Akron, as well as reverse the result reached in American College I, 552 F. Supp. at 797-98, and conceded by the Commonwealth in American College II, 737 F.2d at 293. This is something which I cannot, and will not, do, based upon the weight of authority and the record before me. While increasing the cost and risk of delay of abortions by requiring two trips to an abortion facility, this arbitrary and inflexible

waiting period does not further the state's interest in maternal health and it impermissibly infringes the physician's discretion to exercise sound medical judgment. Therefore, a mandatory 24-hour waiting period unconstitutionally imposes a legally significant burden on a woman's rights to seek an abortion.

This issue is identical to the issue addressed by the Supreme Court in Akron. The Court invalidated a provision that required women, capable of consenting to abortion, to wait a period of 24 hours after giving consent before undergoing an abortion. The Court determined that "if a woman, after appropriate counseling, is prepared to give her written informed consent and proceed with the abortion, a State may

not demand that she delay the effectuation of that decision." Akron, 462 U.S. at 450-51, 103 S.Ct. at 2503.

The record before me amply supports this result. However, I shall only briefly summarize my findings. Only a very small percentage of women are ambivalent concerning whether to have an abortion when they arrive at the facility.[33] Once a woman gives her informed consent to the abortion procedure, there is absolutely no medical reason for delay. In fact, a mandatory 24-hour waiting period could,

33. Special arrangements are made for counseling sessions for women demonstrating any ambivalence about their decision.

in reality, lead to delays in excess of 24 hours and perhaps as long as two weeks given the current practices of abortion providers and the individual circumstances of each patient. Any such delay presents an increased risk to the health of the patient. In some cases, the delay could force the woman into the second trimester of her pregnancy. This would increase the cost of the procedure, as well as the risk.

Moreover, a mandatory 24-hour waiting period would require two visits to the abortion provider. This would double the woman's travel time,[34] her exposure to the harassment of demonstrators located outside of most abortion facilities on a regular basis, and significantly increase her costs in

34. I note that many women must travel substantial distances to reach the nearest abortion provider.

obtaining the procedure. Further, women that work in the home and have children will have to expend additional sums for day care or baby sitting services, and women working outside the home will be required to take additional time off work. The economic impact of this provision will be most burdensome upon those women with the least financial resources, the poor and the young. Finally, women living in rural areas and those women that have difficulty explaining their whereabouts, such as school age women, battered women, and working women without sick leave, will also experience significant burdens in attempting to effectuate their abortion decision, if a mandatory 24-hour waiting period were in place.

The Court's recent validation, in Hodgson, of a 48-hour waiting period for

minors seeking an abortion to permit parental involvement in their decision does not alter this conclusion. In fact, a majority of the Court explicitly distinguished the situation before it from that presented in Akron. See Hodgson, 110 S.Ct. at 2944 n.35, 58 U.S.L.W. at 4965 n.35; see also Ohio, 110 S.Ct. at 2983, 58 U.S.L.W. at 4984 ("The distinction between notifying a minor's parents and informing a woman of routine risks of abortion has ample justification"). Significantly, the statute in Hodgson did not require any delay once the minor obtained the affirmative consent of a substitute decision-maker -- either the court or a parent.

Based upon the record before me, I conclude that the 24-hour waiting period in section 3205 is unconstitutional.

PHYSICIAN-ONLY DISCLOSURE REQUIREMENT

Plaintiffs challenge the provision of section 3205(a)(1) requiring that the information required to be disclosed to the patient pursuant to (a)(1)[35] be imparted by the physician and not his agent. The 1982 version of the Act contained the same requirement. Based upon virtually identical language, the Supreme Court found such a provision unconstitutional. Akron, 462 U.S. at 446-49, 103 S.Ct. at 2501-02. As with

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35. Specifically, section 3205(a)(1), quoted supra at 65-66, requires the physician to orally inform the woman of (1) the nature of the proposed treatment and procedure and of the risks and alternatives to the procedure; (2) the probable gestational age of the fetus at the time the abortion is to be performed; and (3) the medical risks associated with carrying the pregnancy to term.

the 24-hour waiting period provision, the Commonwealth conceded the unconstitutionality of the physician-only disclosure requirement before the Third Circuit. American College II, 737 F.2d at 793. I find that no basis exists in the record before me to reach a contrary conclusion.

The Supreme Court concluded in Akron that it was "unreasonable for a State to insist that only a physician is competent to provide the information and counseling relevant to informed consent," Akron, 462 U.S. at 449, 103 S.Ct. at 2502, since "the State's interest is in ensuring that the woman's consent is informed and unpressured; the critical factor is whether she obtains the necessary information and counseling from a qualified person, not the identity of the person from whom she

obtains it." Id. at 448, 103 S.Ct. at 2502 (emphasis added).

The record before me establishes that prior to performing an abortion, trained counselors at plaintiff-clinics provide a patient with options counseling and obtain her informed consent for the procedure. The record further establishes that these counselors are well-trained and extremely competent to impart such information to patients seeking to terminate their pregnancy. A physician-only disclosure requirement will require the plaintiff-clinics to substantially alter their current practices. Any changes of this nature would necessarily increase costs to the plaintiff-clinics for providing the service, which would undoubtedly be passed along to patients seeking an abortion.

Trained counselors, such as those employed or utilized on a volunteer basis by plaintiff-clinics, are fully capable, by virtue of their training and experience, to provide information to patients, to discuss the alternatives to abortion, and to secure the patient's informed consent. In many instances, trained counselors, who are women, are more understanding than physicians and have more time to spend with the patients. Consequently, in certain cases, the state's interest "in ensuring that the woman's consent is informed and unpressured" may be better served when trained counselors are able to impart the necessary information to the patient. A physician-only disclosure requirement is not narrowly tailored to serve the Commonwealth's interest in protecting maternal health.

Accordingly, I find that the

physician-only informed consent requirements set forth in section 3205(a)(1) of the Act are unconstitutional.

CONTENT-BASED INFORMED CONSENT

"The validity of an informed consent requirement . . . rests on the State's interest in protecting the health of the pregnant woman." Akron, 462 U.S. at 443, 103 S.Ct. at 2499. Plaintiffs do not dispute that a requirement that the woman give what is truly a volunary and informed consent is proper and constitutional. Thornburgh, 476 U.S. at 760, 106 S.Ct. at 2178; Danforth, 428 U.S. at 67, 96 S.Ct. at 2840. However, a state, under the guise of informed consent requirements, "may not require the delivery of information designed 'to influence the woman's informed choice between abortion or childbirth.'"

Thornburgh, 476 U.S. at 760, 106 S.Ct. at 2178 (quoting Akron, 462 U.S. at 443-44, 103 S.Ct. at 2500). Also, rigid requirements that a specific body of information be imparted to a woman in all cases, regardless of the needs of the patient, improperly intrudes upon the discretion of the pregnant woman's physician and thereby imposes an "undesired and uncomfortable straitjacket." See Danforth, 428 U.S. at 67 n.8, 96 S.Ct. at 2840 n.8 (quoted in Thornburgh, 476 U.S. at 762, 106 S.Ct. at 2179).

Section 3205 of the Act states that five specific types of information, three of which must be presented by a physician, must be delivered to the woman at least 24 hours prior to the abortion. The five are: (a) the "nature

of the proposed procedure or treatment and of those risks and alternatives to the procedure or treatment that a reasonable patient would consider material to the decision," (b) the "probable gestational age of the unborn child at the time the abortion is to be performed," (c) the "medical risks associated with carrying her child to term," (d) the fact that the "father of the unborn child is liable to assist in the support of her child," and (e) that "Medical Assistance benefits may be available for prenatal care, childbirth and neonatal care." See 18 Pa. Con. Stat. Ann. § 3205(a)(1) and (2). The woman must also be advised that materials printed and supplied by the Commonwealth that describe the fetus and that "list agencies which offer alternatives to abortion" are available

for her review. See 18 Pa. Con. Stat. Ann. § 3205(a)(2)(i). If the woman elects to review the printed materials, a copy of the materials must be provided to her. See 18 Pa. Con. Stat. Ann. § 3205(a)(3). Finally, the pregnant woman must certify, prior to the abortion, that all of this information has been provided to her. See 18 Pa. Con. Stat. Ann. § 3205(a)(4).

Pursuant to section 3208 of the Act, PaDOH must prepare, publish and update, on an annual basis, easily comprehensible printed materials which would comply with the informed consent provisions of section 3205(a) of the Act. First, PaDOH must prepare "[g]eographically indexed materials designed to inform the woman of public and private agencies" available to assist her through pregnancy. See 18

Pa. Con. Stat. Ann. § 3208(a)(1). Second, PaDOH must prepare "[m]aterials designed to inform the woman of the probable anatomical and physiological characteristics of the unborn child at two-week gestational increments from fertilization to full term, including pictures representing the development of unborn children at two-week gestational increments." See 18 Pa. Con. Stat. Ann. § 3205(a)(2).

The Supreme Court's assessment in Thornburgh of the content-based informed consent imposed by sections 3205 and 3208 of the Act applies with equal force today. For this reason, I shall quote Thornburgh at length. Justice Blackmun wrote:

> The printed materials required by §§ 3205 and 3208 seem to us to be nothing less than an outright attempt to wedge the Commonwealth's message discouraging abortion into

> the privacy of the informed-consent dialogue between the woman and her physician. The mandated description of fetal characteristics at 2-week intervals, no matter how objective, is plainly overinclusive. This is not medical information that is always relevant to the woman's decision, and it may serve only to confuse and punish her and to heighten her anxiety, contrary to accepted medical practice. Even the listing of agencies in the printed Pennsylvania form presents serious problems; it contains names of agencies that may well be out of step with the needs of the particular woman and thus places the physician in an awkward position and infringes upon his or her professional responsibilities. Forcing the physician or counselor to present materials and the list to the woman makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list. All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures -- as it obviously was intended to do -- the dialogue between the woman and her physician.
>
> The requirements of §§ 3205(a)(2)[(ii) and (iii)] that the woman be advised that medical

> assistance benefits may be available, and that the father is responsible for the support of the child similarly are poorly disguised elements of discouragement for the abortion decision. Much of this would be nonmedical information beyond the physician's area of expertise and, for many patients, would be irrelevant and inappropriate. For a patient with a life-threatening pregnancy, the "information" in its very rendition may be cruel as well as destructive of the physician-patient relationship. As any experienced social worker or other counselor knows, theoretical financial responsibility often does not equate with fulfillment. . . . Under the guise of informed consent, the Act requires the dissemination of information that is not relevant to such consent, and, thus, it advances no legitimate state interest.

Thornburgh, 476 U.S at 762-63, 106 S.Ct. at 2179-80 (citations and footnotes omitted); see American College II, 737 F.2d at 295-96; see also Akron, 462 U.S. at 444-45, 103 S.Ct. at 2500-01 (invalidating substantially similar informed consent provisions).

The type of compelled informed

consent contemplated by sections 3205 and 3208 of the Act is the antithesis of informed consent and goes far beyond merely describing the general subject matter relevant to the woman's decision. For this reason, I find that sections 3205 and 3208 are unconstitutional on their face. Thornburgh, 476 U.S. at 764, 106 S.Ct. at 2180.[36]

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36. The Court in Thornburgh concluded as follows: "These statutory defects cannot be saved by any facts that might be forthcoming at a subsequent hearing." Id. I note, however, that my holding does not bar the Commonwealth from preparing the documents required by section 3208. Instead, I merely enjoin the requirement that these items must be offered to the pregnant woman during the informed consent process as outlined by section 3205.

PARENTAL INFORMED CONSENT[37]

> [T]he potentially severe detriment facing a pregnant woman, see Roe v. Wade, 410 U.S. [at 153, 93 S.Ct. at 726] is not mitigated by her minority. Indeed, considering her probable education, employment skills, financial resources, and emotional maturity, unwanted motherhood may be exceptionally burdensome for a minor. In addition, the fact of having a child brings with it adult legal responsibility, for parenthood, like attainment of the age of majority, is one of the traditional criteria for the termination of the legal disabilities of minority. In sum, there are few situations in which denying a minor the right to make an important decision will have consequences so grave and indelible.

Bellotti II, 443 U.S. at 642, 99 S.Ct. at 3047-48.

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37. To the extent that section 3206 required that at least one parent give "informed consent" to the minor's decision, this section must be deemed unconstitutional given the unconstitutional content-based informed consent requirements of section 3205. However, I shall review the constitutionality of parental "informed consent" under the assumption that the informed consent requirements imposed by the Act were in fact constitutional.

Except in the case of a "medical emergency," section 3206 requires a physician to obtain the informed consent of a parent or guardian before performing an abortion on an unemancipated minor or an incompetent woman. Because section 3206 does not define "informed parental consent," I must look to the provisions of section 3205(a) to give meaning to the term. To be "informed" within the meaning of the Act, the physician must have orally informed the parent of all the information required by section 3205(a)(1). In addition, the parent must also be informed of the information required by section 3205(a)(2).

To be constitutional, a parental consent provision must not unduly burden the minor's right to seek an abortion. Bellotti II, 443 U.S. at 640, 99 S.Ct.

at 3046. Although parents may not exercise "an absolute, and possibly arbitrary veto" over the decision, Danforth, 428 U.S. at 74, 96 S.Ct. at 2843, the state's reasonable judgment that the decision should be made after notification to and consultation with a parent has never been questioned. Id. at 75, 96 S.Ct. at 2844; see also Ohio, 110 S.Ct. at 2978-81, 58 U.S.L.W. at 4981-83; Akron, 462 U.S. at 428 n.10, 439, 103 S.Ct. at 2491 n.10, 2497; H.L. v. Matheson, 450 U.S. 398, 409-10, 101 S.Ct. 1164, 1171, 67 L.Ed. 2d 388 (1981). "[P]arental notice and consent are qualifications that typically may be imposed by the State on a minor's right to make important decisions. As immature minors often lack the ability to make fully informed choices that take account of both immediate and long-range

consequences, a State reasonably may determine that parental consultation often is desirable and in the best interest of the minor." Bellotti II, 443 U.S. at 640-41, 99 S.Ct. at 3046-47.

While not explicitly requiring the parent to make an in-person visit to the abortion facility, I conclude, based upon the evidence of record, that an in-person visit to the facility will be necessary under generally accepted medical principles of informed consent in order for the facility to obtain the informed consent of the parent.[38]

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38. I recognize that I reached a contrary conclusion previously. Casey I, 686 F. Supp. at 1126-27. However, I am not bound by my earlier findings. The weight of the evidence at the preliminary injunction hearing did not support plaintiffs' argument. The same, however, cannot be said for the record as it now exists given the credible testimony of Dr. Grodin, a medical ethicist.

Addressing the requirement that a parent make an in-person visit to the facility, I wrote:

> Any requirement that a parent make an in-person visit to the clinic would carry with it the risk of a delay of several days or possibly weeks in obtaining an abortion, even where the parent is willing to consent. It may create additional financial and emotional burdens for the minor and her family. The parent may be obliged to take time off from work, which may entail loss of wages and scheduling difficulties. The parent may incur child care or travel expenses. The parent may be reluctant to explain his or her absence from work, or may not wish to be seen entering an abortion clinic. Such a requirement would also increase the clinics' costs, which would eventually be passed on to their patients.
>
> Because a delay of even a few days can significantly increase the risks and costs associated with abortion, particularly where the minor is near or into her second trimester before she seeks the abortion, the delays inherent in any requirement of an in-person parental consultation could effectively deprive some minors of the right to obtain an abortion. If there is a

> less burdensome means of achieving the Commonwealth's goal of parental involvement in the minor's decision itmust be applied.

Casey I, 686 F. Supp. at 1126.

One could not reasonably dispute that "informed" parental consent would support the Commonwealth's interest in encouraging involvement in the minor's abortion decision so as to enable the parent to determine whether an abortion is in her best interests. Id. However, this interest can be served without requiring an in-person visit by the parent to the abortion provider. Therefore, section 3206 is not narrowly drawn to serve the Commonwealth's interest and unduly burdens the minor's rights. See Planned Parenthood Ass'n of Atlanta Area, Inc. v. Harris, 670 F. Supp. 971, 987-88 (N.D. Ga. 1987).

The question then becomes whether the existence of a judicial by-pass

procedure eliminates this undue burden.[39] The Commonwealth may require the consent of one parent as long as it provides "an alternative procedure whereby a pregnant minor may

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39. Plaintiffs argue that the defendants have failed to sustain their burden of establishing the readiness of the Pennsylvania judiciary to implement the by-pass procedure contained in section 3206, see 18 Pa. Con. Stat. Ann. § 3206(c), (d), (e), and (f), in an expeditious and confidential fashion. Defendants argue that the burden rests with the plaintiffs to establish the non-readiness of the Pennsylvania judiciary to implement the by-pass procedures. I must agree with defendants. Because there is no need to address the sufficiency of the by-pass mechanism since section 3206 has been enjoined for other reasons and because there is no evidence of record to suggest that Pennsylvania's judiciary is not prepared to implement the by-pass procedure, I shall not reach this issue. However, should section 3206 go into effect in the future, plaintiffs may take appropriate action to challenge the sufficiency of the by-pass procedure at that time, if they can establish that Pennsylvania courts are ill-prepared to meet the needs of minor women seeking to avail themselves of the by-pass procedure.

demonstrate that she is sufficiently mature to make the abortion decision herself, or that, despite her immaturity, an abortion would be in her best interests." Akron, 462 U.S. at 439-40, 103 S.Ct. at 2497; see also Ohio, 110 S.Ct. at 2972, 58 U.S.L.W. at 4979 (upholding a single-parent notice requirement with alternative of judicial by-pass); Hodgson, 110 S.Ct. at 2926, 58 U.S.L.W. at 4963 (upholding two-parent notice requirement with alternative of judicial by-pass). The purpose of the by-pass procedure is to eliminate the need for a minor to notify a parent of her decision or the need to obtain a parent's consent. Judicial by-pass acts as a safeguard against the possibility that aparent might attempt to exercise an absolute veto over his or her daughter's decision to obtain an abortion.

No abortion statute considered by

the Supreme Court, including Hodgson and Ohio, has required parental "informed" consent. Nor have the parties identified any such statute for the court. A requirement of informed parental consent, if implemented, would greatly expand the instances in which judicial by-pass would be necessary. Under the requirements of section 3206, a minor who has obtained the consent of a parent will be burdened by the judicial by-pass procedure in order to effectuate her decision, if the parent is unable or unwilling to make an in-person visit to give informed consent for the procedure. Thus, a minor, after communicating with her parent about her decision (either because she was forced to do so under the Act or because she did so of her own volition) and having obtained the concurrence of a parent

that an abortion is in her best interests, will nonetheless have to resort to the more burdensome judicial process, causing unnecessary delay and heightened apprehension and anxiety. Notwithstanding the fact that a by-pass procedure has been considered sufficient, in the judgment of the Supreme Court, both before and after Webster, Hodgson, and Ohio, to eviscerate the burden upon a minor's right to elect to terminate her pregnancy when the state requires notice or consent of a parent prior to the performance of the abortion, I conclude that requiring minors, who would not otherwise have to do so, to resort to ajudicial by-pass procedure imposes an undue burden on the minor's abortion decision and is constitutionally impermissible. Section 3206 is distinct from the statutes considered in Hodgson

and Ohio in that it will require minors who have consulted their parent to endure an otherwise unnecessary judicial by-pass procedure to effectuate their decision.

For the foregoing reasons, I agree with plaintiffs' argument that any requirement of informed parental consent is invalid even when a judicial by-pass procedure is in place. In addition, to the extent that section 3206 does not contain an adequate definition of medical emergency and the content-based informed consent required by section 3205 is impermissible, the Commonwealth will be permanently enjoined from implementing section 3206.

HUSBAND NOTIFICATION

Of all the sections of the Act, this is probably the most problematic. Section 3209 of the Act requires that no physician may perform an abortion on a

married woman unless he or she has received a signed statement from the woman stating that she has notified her spouse that she is about to undergo an abortion. See 18 Pa. Con. Stat. Ann. § 3209(a). However, such notice is not required if the woman certifies: (a) that her spouse is not the father of the child, 18 Pa. Con. Stat. Ann. § 3209(b)(1); (b) that she could not locate her spouse after diligent effort, 18 Pa. Con. Stat. Ann. § 3209(b)(2); (c) that the pregnancy is a result of spousal sexual abuse, 18 Pa. Con. Stat. Ann. § 3209(b)(3); and (d) that she has reason to believe that furnishing notice to her spouse would likely result in the infliction of bodily injury upon her by her spouse or by another individual. 18 Pa. Con. Stat. Ann. § 3209(b)(4). Also, spousal notification is not necessary in cases of a medical emergency as defined

by section 3203. See 18 Pa. Con. Stat. Ann. § 3209(c). The Commonwealth argues that this section furthers its "interest in promoting the integrity of the marital relationship and to protect a spouse's interests in having children within the marriage and in promoting prenatal life of that spouse's child." 18 Pa. Con. Stat. Ann. § 3209(a). Because I conclude that section 3209 is constitutionally defective in that it impermissibly invades a woman's fundamental right to privacy in the abortion decision, I will permanently enjoin the enforcement of this section.

At the risk of repetition, interference with a woman's abortion decision may be justified only by a "compelling state interest" and then the interference must be "narrowly drawn to express only the legitimate state interest at stake." Roe v. Wade, 410 U.S. at 155, 93 S.Ct. at

728. In Roe v. Wade, the Supreme Court identified only two compelling state interests -- (1) an interest in maternal health which becomes compelling after the first trimester of pregnancy and (2) an interest in the protection of a potential human life which becomes compelling at the point of viability. Id. at 154, 163, 93 S.Ct. at 727, 731. If a challenged regulation does not impinge upon a woman's decision to have a first trimester abortion and does not place obstacles in the path of effectuating that decision, the Commonwealth need only demonstrate a rational relationship to a legitimate purpose. See, e.g., Maher v. Roe, 432 U.S. 464, 478-180, 97 S.Ct. 2376, 2385, 53 L.Ed. 2d 484 (1977) (upholding welfare regulations that fund childbirth but do not pay for an abortion unless a physician certifies the abortion is

"medically necessary"); Connecticut v. Menillo, 423 U.S. 9, 96 S.Ct. 170, 46 L.Ed. 2d 152 (1975) (criminal statute proscribing unlicensed physician from performing an abortion does not impinge on abortion decision). However, when a regulation does impose a legally significant burden on the abortion decision and a state's interest has not yet become compelling, "a pregnant woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision 'free of interference by the State.'" Akron, 462 U.S. at 429-30, 103 S.Ct. at 2492 (quoting Roe v. Wade, 410 U.S. at 163, 93 S.Ct. at 731).

Moving through the requisite analysis, I conclude that any statute which requires a physician to notify a third party of a woman's abortion decision is, as a matter of law, a

constitutionally significant burden on the woman's right to an abortion.[40] See Planned Parenthood of Rhode Island v. Board of Medical Review, 598 F.Supp. 625, 633 (D.R.I. 1984) ("PPRI"), see

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40. I note that this situation is distinct from that presented by parental notice or consent provisions which have been upheld by the Supreme Court, see e.g., Hodgson, Ohio, Akron, Danforth, because the state has a compelling interest in assuring familial integrity and the protection of adolescents who may not be sufficiently mature or competent to make that decision. For adult women, the same concern regarding competency and maturity to make this important decision does not exist. See PPRI, 598 F. Supp. at 639. Indeed, absent evidence to the contrary, adult women are presumed to be competent to make such medical decision on their own behalf. For that matter, under Pennsylvania law, a married minor or a minor having a child are considered competent to provide informed consent for any medical procedures. See 35 Pa. Con. Stat. Ann. §§ 10101, 10102. Moreover, even in the context of a minor's abortion decision, the parent cannot bar her from obtaining an abortion, if a court determines that she is competent to make the decision without intervention by a third party.

also Eubanks v. Brown, 604 F.Supp. 141, 148 (W.D. Kent. 1984); Scheinberg v. Smith, 482 F.Supp. 529, 537-38 (S.D. Fla. 1979), aff'd in part and vacated and remanded on other grounds in part, 659 F.2d 476, 482-83 (5th Cir. 1981), on remand, 550 F.Supp. 1112 (S.D. Fla. 1982). However, even if such a notice requirement was not burdensome on its face, the evidence of record convinces me that enforcement of section 3209 would result in a severe impact on and interference with the abortion decision. Accordingly, strict judicial scrutiny of section 3209 would be required.

The pivotal inquiry is whether the challenged law places an obstacle, absolute or otherwise, in the path of a woman's free exercise of her decision. Maher v. Roe, 432 U.S. at 474, 97 S.Ct. at 2382; see also PPRI, 598 F. Supp. at

634 (a state regulation which merely has the potential to frustrate or delay a woman's abortion decision imposes a legally significant burden upon that decision). If Pennsylvania's spousal notification provision is enforced, it will have the effect of delaying or, in some cases, totally frustrating, a woman's decision to have an abortion. Women apprehensive about advising their husbands of their decision may delay in notifying him. Further, assuming one of the proffered interests for a notice requirement -- promoting marital integrity -- was valid, any notice could foster some delay to permit thoughtful marital communication. As previously stated, delay in the performance of an abortion could heighten the risk of complications and mortality. Perhaps more importantly, a forced notification requirement opens the door to total

frustration of the woman's decision. Once advised, some husbands may exert pressure, physical or emotional, to coerce their wives to forego the abortion altogether. In addition, the woman who is forced to notify her husband (because she does not fall within the language of one of the exceptions contained in the Act) in order to obtain an abortion despite her better judgment to the contrary will be subjected to additional anxiety and stress. Finally, when faced with forced notice and her perceived view of the risk such notice poses to her or her family, a pregnant wife may elect a different alternative -- carrying the pregnancy to term or an illegal abortion.[41]

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41. It would be disingenuous for the Commonwealth to claim that any burden (...continued)

Moreover, the existence of limited exceptions to the notice requirements of section 3209 do not alter this conclusion. The exceptions do not provide adequate protection for pregnant wives with perfectly valid reasons for not informing her husband of the decision. First, a pregnant wife, living apart from her husband, must make a "diligent effort" to locate her husband before she can claim an exception to the notice requirement. See 18 Pa. Con. Stat. Ann. § 3209(b)(2). This, as explained in the preceding paragraph, fosters delay and would, therefore, create an undue or

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41. (...continued)

placed upon a woman's right is not the result of state action. The Commonwealth cannot disclaim responsibility for the fact that a husband, once notified, may attempt to prevent an abortion altogether. But for the state requirement of notification, the woman would be able to effectuate her decision freely. PPRI, 598 F. Supp. at 636.

legally significant burden. Second, section 3209 provides an exception to the notice requirement for women whose pregnancies resulted from spousal sexual assault, 18 Pa. Con. Stat. Ann. § 3209(b)(3), but does not provide an exception for women abused sexually in the past in ways not within the rather limited definition of spousal sexual assault. Third, the exceptions do not account for spouses that reasonably fear abuse to their children or for other types of spousal abuse, including psychological or economical, if her husband was notified of her decision. Lastly, the Act does not account for many other numerous legitimate reasons a wife may have for not advising her husband of her abortion decision.[42]

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42. The list of justifications for a women wishing not to involve her husband (...continued)

Having identified a legally significant burden upon the woman's right to terminate her pregnancy, I must now consider whether the Commonwealth

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42. (...continued)

in the decision could include: (a) fear of physical or psychological abuse; (b) fear that such communication would jeopardize the marriage itself; (c) her husband is not the father of the fetus; (d) she was the victim of a rape which she has not disclosed to her husband and she subsequently becomes pregnant; (e) her husband is suffering from an illness and she fears communication concerning the decision could worsen his condition; (f) her husband has strong moral or religious beliefs which lead her to believe that he will object to her decision; (g) she fears her husband will attempt to prevent her from effectuating her decision; (h) she is a battered woman and fears such communication would precipitate future physical violence or other abusive behavior (including psychological and economic abuse) against her, her children or a loved one; and (i) she is recently separated or divorced from her husband. I doubt very seriously that this is an exhaustive list. For this reason, mandatory spousal notice provisions place a legally significant or undue burden on the right of women to decide to terminate their pregnancies.

can justify this burden with a compelling state interest. Admittedly, the Supreme Court has recognized the need to afford the institution of marriage and the family protection from state interference and intervention. See, e.g., Moore v. East Cleveland, 431 U.S. 494, 97 S.Ct. 1932, 52 L.Ed. 2d 531 (1977); Griswold v. Connecticut, 381 U.S. at 479, 85 S.Ct. at 1678. Similarly, the Court has determined that a husband has a constitutionally protected right to procreate. Skinner v. Oklahoma, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 2d d1655 (1942). It is important to note that these cases focused on the protection of these admittedly important rights.

I do not wish to denigrate the importance of these rights. However, in

Eisenstadt v. Baird, the Supreme Court stated:

> [T]he marital couple is not an independent entity with a mind and heart of its own, but an association of two individuals each with a separate intellectual and emotional make-up. If the right to privacy means anything, it is the right of an individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.

Eisenstadt v. Baird, 405 U.S. at 453, 92 S.Ct. at 1038 (emphasis in original).

No Supreme Court case has decided the issue of whether a mandatory spousal notification provision is constitutional. But while acknowledging the importance of protecting the marital relationship and the potential impact the abortion decision could have on the relationship, the Supreme Court concluded that conditioning a woman's abortion decision on the consent of her

spouse was invalid.[43] See Danforth, 428 U.S. at 67-72, 96 S.Ct. at 2840-2842 (since the woman physically bears the child and is more affected by the pregnancy, the state lacks the constitutional authority to give the spouse the unilateral authority to veto his wife's decision to have an abortion).

It is important to note that neither Danforth, despite the clear opportunity to do so, or any other Supreme Court opinion has interposed an additional compelling state interest - either in the marital relationship, protecting the procreation interests of

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43. Previously, the Supreme Court reserved decision on the question of whether a requirement that the consent by the spouse prior to the performance of an abortion could be constitutionally imposed. Roe v. Wade, 410 U.S. at 165 n.67, 93 S.Ct. at 733 n.67.

the husband or promoting prenatal life in the spouse's child - relating to the spouse of a woman seeking an abortion. For the reasons stated above and those contained in PPRI, 598 F. Supp. at 637-40, I conclude that none of these represent a compelling state interest.

The Fifth Circuit's opinion in Scheinberg, upon which defendants rely extensively, does not alter this conclusion. In that case, the court held that mandatory husband notification was justifiable if the state could establish that an aboriton procedure interferes with a married woman's future capacity to have children and, hence, the husband's right to procreate within the marriage. Scheinberg, 659 F.2d at 486-87. After a remand for further consideration of this possibility, the district court found that abortion posed

no increased risk to a married woman's future ability to bear children. Scheinberg, 550 F. Supp. at 1122-23. Because the Commonwealth has not presented any proof that abortion would affect a woman's future child bearing capacity or even advanced this argument, Scheinberg does not support the Commonwealth's argument and, in fact, supports the conclusions reached herein.[44]

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44. I also note that adoption of this argument could have potentially broad consequences upon a married, male or female, individual's autonomy to make procreative choices. An obvious extension of the Commonwealth's alleged interest would be to require an individual to be notified prior to his or her spouse undergoing a sterilization procedure. After all, following the Commonwealth's argument to its logical extreme would suggest that since such operations are permanent, the Commonwealth would have an even more

(... continued)

Considering separately the state's asserted interest in promoting the prenatal life of the spouse's child, the state is essentially attempting to circumvent the holding of Roe v. Wade and its progeny. If the state's interest in the potentiality of life does not become sufficiently compelling until the point of viability so as to permit the state to prohibit abortions except those necessary to protect the life of the mother, then the state's interest in protecting the prenatal life of the spouse's child cannot become compelling until that point. Cf.

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44. (...continued)

significant interest in requiring prior notice. I suspect that the reason that the Commonwealth is proffering this justification in the abortion context is solely because it really wishes to discourage abortion and not encourage marital integrity or protect a spouse's right to procreate within the marriage.

Danforth, 428 U.S. at 69, 96 S.Ct. at 2841 (while recognizing the state's interest in promoting marital integrity and procreation choices, concluding that such interests are not sufficiently compelling for the state to validly delegate the power -- a power which it does not possess itself -- to veto the wife's abortion decision to the husband). Since the Act applies the notice requirement to all trimesters of pregnancy, it must be considered invalid for the state's alleged interest in protecting the prenatal life of a spouse's child could not become compelling until the point of viability, if at all.

Even assuming that the state has a compelling interest in promoting marital integrity, I conclude that section 3209 does not promote that interest. In a

substantial number of cases, the decision to seek an abortion stems from the voluntary consultation of husband and wife. In fact, married couples are often encouraged to consult on important decisions, such as whether to terminate a pregnancy. I doubt that anyone would question the conclusion that a sound marital relationship is one in which communication on sensitive topics, like childbirth and abortion, is routine rather than unusual. However, I, as well as the Pennsylvania legislature, would be ignoring the stark, sometimes tragic, realities of a substantial number of present day marital relationships by assuming that all marriages are predicated on mutual communication, decision-making and respect. Dysfunctional marriages are not uncommon in our society. In many

instances, a pregnant wife may be unwilling, or perhaps unable, to discuss the abortion decision with her husband. See supra at 164 n.42.

Writing for the Court in Danforth, Justice Blackmun commented:

> It seems manifest that, ideally, the decision to terminate a pregnancy should be one concurred in by both the wife and her husband. No marriage may be viewed harmonious or successful if the marriage partners are fundamentally divided on so important and vital an issue. But it is difficult to believe that the goal of fostering mutuality and trust in a marriage, and of strengthening the marital relationship and the marriage institution, will be achieved by giving the husband a veto power exercisable for any reason whatsoever or for no reason at all. Even if the State had the ability to delegate to the husband a power it itself could not exercise, it is not at all likely that such action would further . . . the "interest of the state in protecting the mutuality of decisions vital to the marriage relationship."

Danforth, 428 U.S. at 71, 96 S.Ct. at

2841 (citation omitted). The reasoning of Danforth applies with equal force to compelled mandatory spousal notification.

Marital accord arises from within the relationship not from the intervention of the state. Therefore, forced spousal notification is a totally irrational vehicle to achieve any of the state's purported goals. The record clearly establishes that instead of fostering marital communication and bolstering the state's interest in marital integrity, the exact opposite effect would likely occur. See also Eubanks v. Brown, 604 F. Supp. at 148; PPRI, 598 F. Supp. at 640-42. Not only could forced notice hasten the dissolution of a troubled marriage, but it could have potentially disastrous consequences, including subjecting the

woman to physical abuse.[45] In the words of Governor Casey, "a state cannot intervene in a marital relationship to dictate the relationships between husband and wife." See Veto Message to House at 5 (December 17, 1987) (quoted at length supra at 11 n.13). For this reason and the reasons stated above, I

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45. This is particularly true of battered women suffering from battered woman syndrome, a type of post-traumatic stress disorder. The record before me establishes that many battered women, because of learned helplessness and cycle of violence, would not even be able to avail themselves of the physical abuse exception to the notice requirement. Therefore, these women may elect to continue their pregnancy, seeing no other viable alternative. Dr. Walker's testimony clearly establishes that incidents of abuse are heightened during pregnancy. This heightened abuse during pregnancy coupled with a batterer's anger over his wife's attempt to obtain an abortion (if he somehow discovers this) could result in the serious injury or death of the woman.

will permanently enjoin section 3209 of the Act.

DETERMINATION OF GESTATIONAL AGE

Except in the case of a medical emergency,[46] the Act provides that "no abortion shall be performed or induced unless the referring [or performing] physician . . . first made a determination of the probable gestational age of the unborn child." 18 Pa. Con. Stat. Ann. § 3210(a). The Act further requires the physician to make "such inquiries of the patient and perform or cause to be

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46. To the extent that section 3210 contains the phrase "medical emergency," it is enjoined by earlier portions of this opinion. See supra at 139-42. However, I shall briefly address plaintiffs' challenge to section 3210 which requires an "accurate diagnosis" of the gestational age of the fetus at the time the abortion is performed. The reporting requirements of section 3210 will be addressed below. See infra at 180.

performed such medical examinationsand tests as a prudent physician would consider necessary to make or perform in making an accurate diagnosis with respect to gestational age." Id. (emphasis added). Plaintiffs argue that "Section 3210 requires that the doctor perform a battery of tests to make an 'accurate diagnosis,'" see Plaintiffs' Pretrial Memorandum of Law at 59, and, therefore, will significantly increase the cost of an abortion without any corresponding benefit to any legitimate state interest. On the other hand, defendants maintain that this section does not require the performance of tests to obtain the most accurate diagnosis of gestational age and only those inquiries and tests which a prudent physician would consider to be necessary under

standard medical practice are required. See Defendants' Pretrial Memorandum of Law at 36-38. I agree with the Commonwealth's interpretation of section 3210(a).

A determination of probable gestational age is part of the routine care of a pregnant woman, regardless of whether she is considering terminating her pregnancy. In the abortion context, an accurate determination of gestational age is relevant to the physician's choice of abortion procedure, and the selection of the incorrect procedure could increase the risk of complications for the patient. Ordinarily, an accurate determination of gestational age can be made after review of a woman's menstrual history and a pelvic examination. Unless, considering the circumstances peculiar to the patient, a

prudent physician would perform more tests to obtain an accurate diagnosis of gestational age, the Act requires no more than this.

The requirements of section 3210(a) are reasonably related to the Commonwealth's compelling interest in the protection of maternal health.[47] Section 3210(a) only requires the performance of those tests which a prudent physician would consider necessary to making a determination of gestational age. Consequently, section 3210(a) does not seek a departure from generally accepted medical standards. Thus, I perceive no burden on the

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47. To the extent that a determination of gestational age may be useful as an indicator of viability for pregnancies near the end of the second trimester, then the state's interest in the potentiality of life also becomes compelling.

woman's right to choose an abortion under this section.

This conclusion is supported by the Supreme Court's decision in Webster. In that case, the Court upheld a Missouri statute which reads as follows:

> Before a physician performs an abortion on a woman he has reason to believe is carrying an unborn child of twenty or more weeks gestational age, the physician shall first determine if the unborn child is viable by using and exercising that degree of care, skill, and proficiency commonly exercised by the ordinarily skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. In making this determination of viability, the physician shall perform or cause to be performed such medical examinations and tests as are necessary to make a finding of gestational age . . .

Webster, ___ U.S. at ____, 109 S.Ct. at 3054 (quoting Mo. Rev. Stat. § 188.029). The plurality determined that this section of the Missouri Act

did not require a physician to perform tests which "would be irrelevant to determining viability or even dangerous to the mother and the fetus." Id. at __, 109 S.Ct. at 3055 (plurality); id. at__, 109 S.Ct. at 3060-64 (O'Connor, J., concurring in judgment); id. at ___, 109 S.Ct. at 3064 (Scalia, J., concurring in judgment).[48]

Because I conclude that section 3210(a) requires only those tests and inquiries that a prudent physician would consider necessary under standard medical practice for the determination

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48. While I recognize that this conclusion was sharply critized by the dissenting opinion of Justice Blackmun joined by Justices Brennen and Marshall, id., at _____, 109 S.Ct. at 3068 n.1, as well as the dissenting opinion of Justice Stevens, id. at _____, 109 S.Ct. at 3079-80, this reasoning did secure the approval, at least in the narrowest possible sense, of five members of the Court.

of gestational age, and because this section protects the Commonwealth's compelling interest in protecting maternal health without imposing an undue burden on a woman's right to choose an abortion, the requirement in section 3210(a) that a physician make a determination of gestational age is constitutional.[49]

PUBLIC DISCLOSURE REQUIREMENTS

Record keeping and reporting requirements which are reasonably directed to the preservation of maternal health and which properly respect a patient's confidentiality and privacy are permissible. Danforth, 428 U.S. at

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49. Plaintiffs filed a motion for partial summary judgment on this issue. By separate order, I shall deny this motion for the reasons stated herein.

80-81, 96 S.Ct. at 2846; see also Thornburgh, 476 U.S. at 766, 106 S.Ct. at 2181; Casey I, 686 F. Supp. at 1129.

Sections 3207(b) and 3214(f) require that every facility at which abortions are performed file certain reports.[50] Plaintiffs argue that the provision which subjects these reports to public inspection, if the facility received state appropriated funds during the preceding 12 months regardless of the amount or the type of funding, is unconstitutional. The Commonwealth attempts to justify the reports on the ground that the public has a right to know how its tax dollars are spent.

When first presented with this issue in 1982, I concluded that

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50. Importantly, plaintiffs do not challenge the requirement that they file reports under sections 3207(b) and 3214(f).

plaintiffs had not established that disclosure would impose a legally significant burden on the abortion decision. American College I, 552 F. Supp. at 803-04. Similarly, the Third Circuit determined that the plaintiffs had not "as yet demonstrated a nexus between the disclosure of such information and the chilling of constitutional rights." American College II, 737 F.2d at 297. Not long after that, I found that public disclosure of these reports would impose a legally significant burden on a woman's fundamental right to obtain an abortion. American College III, 613 F. Supp. at 666. Only two years ago, I stated "[t]he evidence of record in this action persuades me that the situation has not changed." Casey I, 686 F. Supp. at 1129. Once again, I am convinced, on

the basis of the record presently before me, that the public disclosure requirements contemplated by sections 3207(b) and 3214(f) impose a legally significant burden on a woman's right to obtain an abortion.

Abortion facilities, physicians and their staffs remain under intense pressure from anti-abortion demonstrators. In fact, in recent months, this pressure has become more onerous. The pattern of hostile behavior which has developed in the past includes picketing and verbal harassment of clinic physicians and staff members at the facilities, their private offices and their homes. Pregnant women must also suffer extreme harassment upon entering a facility. While verbal harassment is most common, attempts to block egress and ingress at a facility,

forced entries into abortion clinics as well as pushing and shoving have become more commonplace. Death, bombing and kidnapping threats also have been documented.

While this activity comes from members of the public, and not from the Commonwealth, any action of the Commonwealth which may increase the risk of harassment must be carefully scrutinized.[51] Casey I, 686 F. Supp. at 1129; see also Brown v. Socialist Workers' 74 Campaign Comm., 459 U.S. 87,

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51. The Commonwealth's argument that the plaintiff-clinics subject themselves to such harassment by advertising in telephone directories is without merit. American College III, 613 F. Supp. at 669. I find that public disclosure of reports under sections 3207(b) and 3214(f) creates a reasonable probability that plaintiff-clinics, other abortion providers, and patients will be subjected to increased threats and harassment.

103 S.Ct. 416, 74 L.Ed. 2d 250 (1982) (evidence of specific incidents of private and government hostility towards the Socialist Workers Party and its members during the four years preceding trial was sufficient to establish that disclosure would chill first amendment rights of association); Buckley v. Valeo, 424 U.S. 1, 74, 96 S.Ct. 612, 661, 46 L.Ed. 2d 659 (1976) ("[t]he evidence offered need show only a reasonable probability that the compelled disclosure of a party's contributors' names will subject them to threats, harassment, or reprisal from either Government officials or private parties"); National Ass'n for the Advancement of Colored People v. Alabama ex rel. Patterson, 357 U.S. 449, 78 S.Ct. 1163, 2 L.Ed. 2d 1488 (1958) (in light of evidence of past incidents of

retaliation upon disclosure, compelled disclosure of the NAACP's membership is likely to affect adversely the ability of petitioner and its membership to pursue their collective effort).

A regulation designed to inform the public about public expenditures does not further the Commonwealth's interest in protecting maternal health. Therefore, such a regulation cannot justify a legally significant burden on a woman's right to obtain an abortion. Moreover, I once again note that there are less obtrusive means through which the Commonwealth may satisfy the public's need to know how funds are spent. See Casey I, 686 F. Supp. at 1129-30.

Therefore, I will permanently enjoin the provisions of sections 3207(b) and 3214(f) which provide for the public disclosure of reports.

REPORTING REQUIREMENTS

Plaintiffs challenge various reporting requirements contained in sections 3214(a) and 3214(h). At the outset, it is important to note that the information to be reported under sections 3214(a) and 3214(h) will, by statute, remain confidential.[52] Further, the record before me suggests that the statutory provisions regarding the confidentiality of these reports will be strictly enforced. PaDOH has taken the necessary measures to ensure

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52. The reports are not public records within the meaning of Pennsylvania's Right-to-Know law, 65 Pa. Cons. Stat. Ann. §§ 66.1 to 66.4. 18 Pa. Con. Stat. Ann. § 3214(e)(2). Disclosure may be made to law enforcement officials only upon an order of the Court of Common Pleas after application showing good cause. Id. PaDOH's statistical report shall not lead to the disclosure of the identity of any physician, facility, or patient. See 18 Pa. Con. Stat. Ann. § 3214(e)(1).

compliance with the Act and that these reports will not be subjected to public disclosure. Standing alone, however, this may not be sufficient to withstand constitutional challenge. Casey I, 686 F. Supp. at 1130. Reporting requirements which "pose an unacceptable danger of deterring the exercise" of a woman's right to end a pregnancy must be invalidated. Thornburgh, 476 U.S. at 767-68; 106 S.Ct. at 2182.

Before turning to plaintiffs' specific challenges to these reporting requirements, I note that plaintiffs argue that the reporting requirements of section 3214 will impose a significant financial burden on the clinics, which will be passed on to their patients. The evidence of record suggests that plaintiff-clinics have, in fact, incurred additional administrative costs

as a result of the reporting requirements. However, there was no testimony which suggests that any of the plaintiff-clinics have raised the fees for an abortion because of these added expenses. Further, I find that the additional cost to plaintiff-clinics is not so great that, in and of itself, it imposes a legally significant burden on the right to obtain an abortion.

Plaintiffs first specifically challenge the requirement of section 3214(a)(1) that the referring physician, if any, and the performing physician be identified on the individual abortion report.[53] Each requires a separate

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53. It does not appear that plaintiffs challenge the requirement that the concurring physician and second physician required by sections 3211(c)(2) and 3211(c)(5) also be (... continued)

analysis. As to the performing physician, he or she is the best person to answer the questions of PaDOH which may arise as a result of the information contained on the report or errantly omitted from the report. While often plaintiff-clinics have contact persons to handle PaDOH inquiries concerning the reports, PaDOH has still, on occasion, been required to contact the performing physician directly. Further, for those abortion procedures not performed in abortion facilities, direct contact with the physician may be required. I am not

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53. (... continued)

reported. This would only apply to abortions performed at 24 or more weeks gestation. Therefore, I shall not address these requirements at length herein. However, for substantially the same reasons that the reporting of the identity of the performing physician is reasonably related to the Commonwealth's interest in promoting maternal health, I find these requirements to be constitutional.

unmindful of the fact that some physicians who previously performed abortions may be deterred from doing so under the Act. However, while plaintiff-clinics may have had more difficulty in locating doctors to perform abortion procedures, the record is void of any evidence that a physician refused to perform abortions for any of the plaintiff-clincs because of the reporting requirements and void of any evidence that plaintiff-clinics have not been able to sustain the apparent demand for the abortion services they provide. Because I conclude that the requirement that the performing physician be included on the abortion report is reasonably related to the Commonwealth's interest in promoting maternal health, and is narrowly tailored to serve that

interest,[54] I will reject plaintiffs' challenge to this specific reporting requirement.

The requirement that the referring physician, if any, be identified on the individual report does not add to the pool of scientific knowledge concerning abortion. Nor is it reasonably related to the Commonwealth's interest in promoting maternal health. See Casey I, 686 F. Supp. at 1130. The evidence of

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54. Plaintiffs suggest that the performing physician could be identified by license number, instead of by name, and the Commonwealth could easily cross-reference the number to obtain the physician's name if it needed to contact the physician directly. I assume that, if the physician's license number were to be disclosed in some manner, another party with sufficient interest could also determine the physician's name from the number. Similarly, requiring the Commonwealth to obtain the physician's name from hospital records would not be a less intrusive means for the Commonwealth to follow-up on individual abortion reports. Casey I, 686 F. Supp. at 1130-31.

record persuades me that, notwithstanding the provisions pertaining to confidentiality of reports submitted to PaDOH, many physicians, particularly those that previously discontinued performing abortions because of harassment, will refuse to refer patients to abortion clinics if their names will appear on these reports. This would result in the imposition of an undue burden on the woman's ability to obtain an abortion.

To the extent that the Commonwealth may seek missing information contained on the individual abortion report, the ability and responsibility to provide that information rests with the abortion facility and the performing physician, not the referring physician. The Commonwealth also asserts that disclosure of the referring physician's

identity is necessary because "[t]he referring physician is capable of giving informed consent required by § 3205 and making a determination of gestational age required by § 3210." See Defendants' Pretrial Brief at 40. This argument is without merit. The abortion provider, especially an abortion clinic, will review informed consent information with the patient prior to performing the procedure, regardless of what the referring physician may or may not have done. The same holds true for a determination of gestational age. Failure to do so would be tantamount to inviting a malpractice suit. Therefore, the performing physician or abortion facility will have all information the Commonwealth might seek in either of these two areas at their disposal. Finally, to the extent that the

referring physician is involved in the post-abortion care of the patient, he is required to make an appropriate report of any complications under section 3214(h).

Plaintiffs also challenge the requirement that the facility report any medical complications arising out of pregnancy or from the abortion procedure, 18 Pa. Con. Stat. Ann. § 3207(a)(7),[55] and that any treating physician file a report of complications arising from the abortion procedure.

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55. Previously, plaintiffs challenged the section of the Report of Induced Terminations of Pregnancy, relating to medical complications of pregnancy. I concluded that this section was "unartfully drafted" but refrained from ruling on the merits of plaintiffs' constitutional challenge to this portion of the form. See Casey I, 686 F. Supp. at 1133. Since that time, the Commonwealth amended the form to eliminate the problem. Plaintiffs no longer make this challenge. See Defendants' Exhibit 47B.

18 Pa. Con. Stat. Ann. § 3214(h). Plaintiffs argue that these reports will yield scientifically inaccurate data because of (1) a facility's unawareness of post-abortion complications in many cases; (2) the absence of uniform definitions for complications; and (3) the possibility that there may be double-reporting of complications (by the facility and a subsequent treating physician). Essentially for the reasons stated in my earlier opinion, I find this argument to be without merit. See Casey I, 686 F. Supp. at 1131. While the data gathered by these reports may not perfectly reflect all medical complications, I am not persuaded that the information is statistically meaningless. Because sections 3207(a)(7) and 3214(h) are reasonably related to the Commonwealth's

interest in protecting maternal health, I reject plaintiffs' challenge to these reporting requirements.

Next, the plaintiffs challenge the requirement that the physician report the basis for his medical judgment concerning viability (section 3214(a)(8)), the existence of a medical emergency (section 3214(a)(10)), and determining gestational age (section 3214(a)(11)). I will permanently enjoin the enforcement of these provisions for the reasons set forth in my ruling on plaintiffs' motion for a preliminary injunction. See Casey I, 686 F. Supp. at 1132 (for a "physician [to] justify his medical judgment by reporting the basis therefor in a written report impermissibly interferes with the woman's ability to effectuate her abortion decision" and has a chilling

effect upon the physician's exercise of his judgment).

Finally, plaintiffs challenge the Commonwealth's attempt to include inquiries concerning Hispanic origin, race, educational level, and date of last normal menses on the Report of Induced Termination of Pregnancy. While none of these items appear in the Act, the Commonwealth argues that PaDOH may legally go beyond the requirements of the statute and request this additional information.[56] PaDOH's stated purpose in requesting this information is to (1)

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56. Indeed, a reading of the applicable statutory provisions seems to support this argument. For example, section 3214(a) requires only that the forms "include" the information listed in the statute. Similarly, section 3214(h) provides that the form shall contain "such other information except the name of the patient as the department from time to time require[s]."

be consistent with the federal standards for the collection of data on induced terminations of pregnancy which were developed by the National Center for Health Statistics and (2) better study the three outcomes of pregnancy (live births, fetal deaths, and induced terminations of pregnancy) for which the Division of PaDOH collects data.

The Handbook on the Reporting of Induced Terminations of Pregnancy prepared by the federal government, through the National Center for Health Statistics, United States Department of Health and Human Services states:

> Data from reports of induced termination of pregnancy provide unique information on the characteristics of women having induced abortions. Uniform annual data of such quality are nowhere else available. Medical and health information is provided to evaluate risks associated with induced abortion at various lengths of gestation and by the

> type of abortion procedure used. Information on the characteristics of the women is used to evaluate the impact that induced abortion has on the birth rate, teenage pregnancy, and out-of-wedlock births. The data also help measure the role that induced abortion plays in birth prevention as compared with contraception. Because these abortion data provide information necessary to promote and monitor health, it is important that the forms be completed carefully.

See Defendants' Exhibit 43 at 2. The "Standard Report of Induced Termination of Pregnancy," intended to serve as a model for the states, is virtually identical to the Pennsylvania Report.

Moreover, abortion is another "pregnancy outcome," in addition to live births and fetal deaths, upon which the Division of PaDOH gathers information. The same information is collected on the Certificate for Fetal Death, which must be submitted to PaDOH on each instance of fetal death after 16 weeks of gestation, and on the Certificate of

Live Birth, which must be submitted to PaDOH upon each instance of live birth. Therefore, the Commonwealth maintains that it must be able to collect this information to supplement the information already received on these two forms to enable it to better study the three possible pregnancy outcomes -- specifically, through the examination of socio-economic information useful in examining fertility rates and for family planning purposes.

The Act, as originally enacted in 1982, required the individual abortion report to contain the same information regarding the woman's personal history.[57] In addition, the Act

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57. The demands for information regarding Hispanic origin and educational level did not appear in the original Act.

provided that each report "shall be made available for public inspection and copying within 15 days of receipt in a form which will not lead to the disclosure of the identity of any person filing a report." Similarly, the complications report was to be open for public inspection and copying. In respect to the individual reporting requirements and the availability of these reports for public inspection, the Supreme Court concluded:

> The scope of information required and its availability to the public belie any assertions by the Commonwealth that it is advancing any legitimate interest. . . .
>
> The required Pennsylvania reports[,] . . . while claimed not to be "public," are available nonetheless to the public for copying. Moreover, there is no limitation on the use to which the Commonwealth or the public copiers may put them. . . . The decision to terminate a pregnancy is an intensely private one that must be protected in a way that assures anonymity. . . .

A woman and her physician will

necessarily be more reluctant to choose an abortion if there exists a possibility that her decision and her identity will become known publicly. Although the statute does not specifically require the reporting of the woman's name, the amount of information about her and the circumstances under which she had an abortion are so detailed that identification is likely. Identification is the obvious purpose of these extreme reporting requirements. . . .
... Pennsylvania's reporting requirements raise the specter of public exposure and harassment of women who choose to exercise their personal, intensely private, right, with their physician, to end a pregnancy. Thus, they pose an unacceptable danger of deterring the exercise of that right, and must be invalidated.

Thornburgh, 476 U.S. at 765-68, 106 S.Ct. at 2181-82.

While the Commonwealth removed many of these same reporting requirements from the Act, PaDOH still seeks to collect information in these areas for the reasons expressed above. Based upon the record before me, I do not find any

legally significant burden to a woman'sright to choose to terminate her pregnancy by these requirements. These reports are now secure from public disclosure. See 18 Pa. Con. Stat. Ann. § 3214(e)(2); see also 18 Pa. Con. Stat. Ann. § 3214(e)(1) (the annual statistical report shall not disclose any information which would lead to the disclosure of the identity of any person about whom a report is filed). Public disclosure of these reports was of substantial concern to the Supreme Court in Thornburgh. But the same danger of public exposure and harassment does not exist given the current restrictions contained in the Act. Further, no substantial additional burden would be imposed upon the plaintiff-clinics or other abortion providers to gather and report this information. As stated previously, these additional costs are

not legally significant. In fact, some, if not all, of this information is already collected on medical history forms by abortion providers.

Inasmuch as no legally significant burden has been demonstrated by plaintiffs, the Commonwealth need only demonstrate a rational basis for the reporting requirements. American College I, 552 F. Supp. at 796. Based upon the fully developed record before me, I find that the Commonwealth has sustained that burden. This information will permit the Commonwealth to assimilate data pertinent to all three possible pregnancy outcomes, and compile useful information concerning fertility rates, family planning, and, hence, maternal health. Because I conclude that compiling this information is rationally related to a legitimate

government interest and does not impose a legally significant burden on a woman's right to end her pregnancy, I reject plaintiffs' argument that I should permanently enjoin the Commonwealth from seeking to collect this data.[58]

In summary, except insofar as the Act requires the reporting of the name of the referring physician and the basis for the physician's medical judgment, I conclude that the reporting requirements of sections 3214(a) and 3214(h), including the additional information

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58. I recognize that I reached a contrary conclusion in my ruling on plaintiffs' motion for a preliminary injunction. Casey I, 686 F. Supp. at 1133. However, I am not bound by that ruling herein. After careful consideration of the more expansive record before me, I conclude that this situation is, in fact, distinguishable from that presented in Thornburgh.

sought by the Commonwealth but not required by the Act, are constitutionally valid.[59] I shall sever those two requirements and permit the Commonwealth to collect all other data required by the Act and approved of herein.

SEVERABILITY

During argument, defendants contend that the Act's "very liberal severance provision" permits this court to strike "any word, phrase or provision" found to

59. Of course, the Commonwealth may not require the reporting of information relating to the husband notification and parental consent sections because those sections have been permanently enjoined by other sections of this opinion.

be unconstitutional.[60] See Trial Transcript, Vol. IV at 49. However, it is not my function to surgically repair legislation to bring it within constitutional limits, if such surgical reconstruction would result in a statute which would be virtually unrecognizable to the legislative body responsible for enacting the legislation in the first place. See Thornburgh, 476 U.S. at 764-65, 106 S.Ct. at 2181 (radical dissection of the Act which would leave it with little resemblance to that intended by the legislature is improper);

60. The severability clause states as follows:

> The provisions of this Act are severable. If any word, phrase or provision of this Act or its application to any person or circumstance is held invalid, the invalidity shall not affect any other word, phrase or provision or application of this Act which can be given effect without the invalid word, phrase, provision or application.

See 1989 Pa. Laws 592, 603, § 6.

Akron, 462 U.S. at 445 n.37, 103 S.Ct. at 2501 n.37 (rejecting invitation to sever subsections of informed consent provision despite presence of broad severability clause); Carter v. Carter Coal, 298 U.S. 238, 56 S.Ct. 855, 80 L.Ed. 2d 1160 (1936) (severability clause does not authorize court to give statute meaning entirely different than that intended by legislature); Roe v. Casey, 623 F.2d at 837 (court may not substitute its judgment for that of elected officials to rescue otherwise invalid statute). For this reason, I have exercised extreme caution in my determinations of whether to sever certain requirements of the Act.

While I have elected to sever certain of the reporting requirements from the Act, I decline the

Commonwealth's invitation to engage in more substantial dissections of the Act. For example, I will not strike the word "informed" from section 3206, relating to the requirement of informed parental consent as suggested by the Commonwealth. See Trial Transcript, Vol. IV at 49. Because "consent" and "informed consent" have radically different meanings, striking the word "informed" from section 3206 would give the section a radically different meaning than that intended by the legislature and, therefore, be improper. The same is true for the language contained in the Act's definition of "medical emergency."

IV.

CONCLUSIONS OF LAW

Inasmuch as I find that I have subject jurisdiction over this action

pursuant to 28 U.S.C. §§ 1331, 1343(a)(3),(4) and based upon the foregoing findings of fact and discussion, I conclude that portions of the Act are unconstitutional and, therefore, the defendants must be permanently enjoined from enforcing those portions of the Act. Other portions of the Act, in my opinion based upon the record before me, are constitutional, and plaintiffs' challenges to those sections are rejected. My conclusions can be summarized as follows:

a. The definition of "medical emergency" contained in section 3203 is unconstitutional, and all sections of the Act containing the term must be permanently enjoined. This includes, but is not limited to, the following sections: section 3205 (informed

consent), section 3206 (informed parental consent or judicial by-pass), section 3209 (spousal notification), section 3210 (determination of gestational age), and section 3211 (performance of abortions after 24 weeks of gestation).

b. Because any attempt to severe the constitutionally offensive aspects of the definition of "medical emergency" would result in language contrary to the intention of the legislature, I cannot utilize the Act's savings clause to prevent the permanent injunction of these sections.

c. The 24-hour waiting period, physician-only disclosure requirement, and the content-based informed consent requirements contained in section 3205 are constitutionally invalid and must be permanently enjoined. Any attempt to

sever the constitutionally offensive language from these sections would be improper.

d. The requirement of informed parental consent, in and of itself, is unconstitutional, notwithstanding the existence of a judicial by-pass procedure, because it unduly burdens a minor woman's right to elect to end her pregnancy and is not narrowly drawn to serve the state's interest. Hence, section 3206 must be permanently enjoined for this reason. In addition, because of the absence of a constitutionally valid definition of "medical emergency" and "informed consent," section 3206 must be permanently enjoined for these reasons as well.

e. The requirement of husband notification contained in section 3209

is unconstitutional and, therefore, must be permanently enjoined in its own right.

f. Section 3210 which requires the physician to make such inquiries and perform or cause to be performed such tests to make an accurate diagnosis of gestational age is constitutional.

g. The requirement under sections 3207(b) and 3214(f) that certain forms be made available for public disclosure creates an unconstitutional burden upon the woman's abortion decision, and I shall enjoin the enforcement of these sections.

h. Except insofar as section 3214(a) requires the reporting of the name of the referring physician (section 3214(a)(1)) and the basis of the physician's medical judgment (section 3214(a)(8),(10), and (11)), I find the balance of section 3214(a) is

constitutional. In addition, section 3214(h) requiring the submission of reports on complications is constitutional.

i. Because a woman's abortion decision is not unduly burdened by the reporting of information of marital status, Hispanic origin, date of last menses, race, and educational background and this information is reasonably related to the state's interest in protecting maternal health, I conclude that requiring these items to be reported are constitutional.

V.

CONCLUSION

For now, at least, the law of abortion remains undisturbed, because only the United States Supreme Court has

the power to change it.[61] But those individuals who have felt secure over the past seventeen years with the fundamental right, and the protections which flow therefrom, guaranteed by Roe v. Wade would be wise to heed Justice Blackmun's admonition -- "the signs are evident and very ominous, and a chill wind blows."[62]

What the future holds is not certain. But one thing must be evident. Individuals can no longer feel as secure with the protections provided by the judiciary in this area. Instead, a woman's privacy rights and individual autonomy may soon be subjected to the

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61. This, of course, does not preclude the Third Circuit from disagreeing with the findings and conclusions reached herein.

62. Webster, ___ U.S. at ____, 109 S.Ct. at 3079 (Blackmun, J., dissenting).

vicissitudes of the legislative process. Therefore, the protection afforded will depend on the ballot box, and the nature of the protection, if any, could vary from term-to-term depending on the composition of the legislature. If unprotected by their vote and the votes of other pro-choice advocates, many women will be forced to seek abortion services elsewhere. For those that can afford it, this may only mean traveling to another jurisdiction. For those that cannot, the result may well be disastrous and tragic. But for now, at least, the law of abortion remains undisturbed.

An appropriate order follows.

/s/
Daniel H. Huyett, 3rd, Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, REPRODUCTIVE HEALTH AND ACTION COUNSELLING CENTER, WOMEN'S HEALTH SERVICES, INC., WOMEN'S SUBURBAN CLINIC, ALLENTOWN WOMEN'S CENTER and THOMAS ALLEN, M.D. on behalf of himself and all others similarly situated, Plaintiffs,	: CIVIL : ACTION NO. : 88-3228
v.	
ROBERT P. CASEY, N. MARK RICHARDS, ERNEST PREATE, personally and in their official capacities, and MICHAEL D. MARINO, personally and in his official capacity, together with all others similarly situated, Defendants.	

ORDER

HUYETT, J. August 24, 1990

Upon consideration of evidence submitted by the parties during the trial, the evidence presented during the preliminary injunction hearing admitted for the purpose of trial, the pretrial memoranda and submissions of plaintiffs

and defendants, the arguments of counsel, and the post-trial memoranda and submissions of the parties, and based upon the attached findings of fact, discussion and conclusions of law, it is ORDERED that

Judgment is entered in FAVOR of plaintiffs and AGAINST defendants in a manner consistent with the attached opinion.

IT IS FURTHER ORDERED that:

1. Defendants are hereby permanently enjoined from implementing and enforcing all provisions of the Pennsylvania Abortion Control Act of 1982, as amended by Act 31 and Act 64, that contain the term "medical emergency" as defined in section 3203 of the Act.

2. Defendants are hereby permanently enjoined from implementing

and enforcing any and all provisions of section 3205 of the Pennsylvania Abortion Control Act of 1982, as amended by Act 31 and Act 64.

3. Defendants are hereby permanently enjoined from implementing and enforcing any and all provisions of section 3206 of the Pennsylvania Abortion Control Act of 1982, as amended by Act 31 and Act 64.

4. Defendants are hereby permanently enjoined from implementing and enforcing any and all provisions of section 3209 of the Pennsylvania Abortion Control Act of 1982, as amended by Act 31 and Act 64.

5. Defendants are hereby permanently enjoined from disclosing or otherwise making available for public inspection and copying any report that has been filed or that may be filed

pursuant to sections 3207(b) or 3214(f) of the Pennsylvania Abortion Control Act. of 1982, as amended by Act 31 and Act 64.

6. Defendants are hereby permanently enjoined from implementing or enforcing the provisions of section 3214(a)(1), insofar as it requires the identification of the referring physician, and sections 3214(a)(8), 3214(a)(10), and 3214(a)(11), insofar as they require the identification of the basis for the physician's medical judgment, of the Pennsylvania Abortion Control Act of 1982, as amended by Act 31 and Act 64.

7. Defendants are hereby enjoined from distributing or utilizing the Pennsylvania "Report of Induced Termination of Pregnancy" except in an appropriate form consistent with the

discussion and conclusions of law contained in the foregoing opinion.

IT IS SO ORDERED.

/s/
Daniel H. Huyett, 3rd, Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

PLANNED PARENTHOOD OF SOUTHEASTERN PENNSYLVANIA, REPRODUCTIVE HEALTH AND ACTION COUNSELLING CENTER, WOMEN'S HEALTH SERVICES, INC., WOMEN'S SUBURBAN CLINIC, ALLENTOWN WOMEN'S CENTER and THOMAS ALLEN, M.D. on behalf of himself and all others similarly situated, Plaintiffs,	: CIVIL ACTION NO. 88-3228
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ORDER

HUYETT, J. August 24, 1990

Upon consideration of plaintiffs' motion for partial summary judgment and supporting memoranda, defendants' response, and for the reasons stated in my opinion issued this date, Plaintiff's

motion is DENIED.

IT IS SO ORDERED.

/s/
Daniel H. Huyett, 3rd, Judge